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Health Practices of the Poor

LOLA M. IRELAN*

IN ALMOST EVERY PHASE of health care and behavior, the poor behave differently from the middle class and more affluent sectors of American society. They have higher prevalence rates for many diseases, including schizophrenia. They have less accurate health information. Illness is defined differently. They are less inclined to take preventive measures, delay longer in seeking health care, and participate less in community health programs. When they do approach health practitioners, they are more likely to select subprofessionals. And, under the care of professionals, they are apt to be treated differently from better-off patients.

At first glance, such a situation appears incredible. In an area such as health, where science and human need are most poignantly juxtaposed, one might expect highly rational, objectively determined behavior. Particularly in America, so bemused are we by the mystique of "science," action which seems to fly in the face of scientific knowledge is startling. Yet, in health measures as in other categories of human behavior, people are strongly influenced by their social identities. Between societies, and between different segments of single societies, health-related behavior varies markedly.

Only recently have practitioners given attention to the social elements in health patterns. Basic problems of acquiring knowledge about physical disease itself were formerly so great that the knotty problem of applying knowledge was neglected. Now, with a formidable bulk of available medical knowledge, and almost society-wide facilities for implementing it, we are discovering the potency of social barriers to such implementation. Ironically, it appears that the people most in need of medical services are the ones who least often procure them. The poor are simultaneously subjected to increased health hazards and insulated from sources of help.[1] The beliefs and attitudes with which they adapt to a deprived existence act at the same time to perpetuate deprivation.

In a democratic society, such a condition is ideologically intolerable. In any society, it is economically unsound. Poor health is often an immediate cause of public dependency. It can contribute to intergenerational poverty.[2]

Correcting the situation requires social as well as medical tools. Circumvention of social factors is an intricate, sensitive project at best. It can be fully successful only when relevant values and social relationships are well understood. The welfare profession's age-old concern for the health of its clients must be supplemented by increased interest in their view of life and in the patterns of social

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*Division of Research, Welfare Administration. This is the third in a series of research essays on low-income life styles. The first two essays, on "Low-Income Outlook on Life" and "Economic Deprivation and Family Patterns," appeared in the September 1965 issue of Welfare in Review.

For references cited, see end of article.

relationships surrounding health practices in low-income strata.

Considerable descriptive information is already available on the sociocultural elements in health behavior. Comparative studies of total societies have demonstrated graphically the impact of differing values and social patterns.

Research to date reveals many similarities between cross-cultural and social class differences in health behavior. In the research summary which follows, a preliminary discussion of the variations between total societies will underline the subtler but similar disparities within our own society.

HEALTH DIFFERENCES BETWEEN SOCIETIES

Human physiology is a constant. One human is constructed and functions pretty much the same as another. We are nourished in the same way, digest food similarly, conceive and bear children similarly, and are subject to the same diseases and injuries. Susceptibility to pain is the same and at about the same level for all humans. Even psychological capacities are strikingly consistent. Witness the ease with which children can be socialized to the patterns of any culture.

Yet definitions and treatment of health problems are different in every separate cultural setting. Considerable diversity exists, both in choices of phenomena to be labeled as health problems and in the treatment of ill health.

"Health" of any sort--mental, physical, moral, or what have you--is socially defined. Unless people label a condition for themselves as one of disease or disorder, it is not a health problem in their society. In some societies, a physical disorder may be so common as to be considered natural, unavoidable, and compatible with normal good health. For example, in the early 1900's in some regions of southern North Africa, hookworm was so widespread as to seem inescapable. No attempt was made to treat it. Indeed, programs to fight hookworm infestation were resisted in many places.[3]

The definition of mental health is especially susceptible to cultural influences. For whatever reasons the selection is made, each people applies its own standards to support some types of extreme personality, tolerate others, and reject still other personalities--usually those disruptive in the particular society where they occur.[4]

Variations in the treatment process seem to be related to technological development. As with most other functions, the practice of medicine seems to become more specialized and depersonalized as technology advances. In simpler groups, individual persons are likely to be relatively self-sufficient and unspecialized in their work. The treatment of disease, even by a socially recognized practitioner, is usually done in a more personal manner. Practices in Mexican-American folk communities illustrate this point. Mild disorders are treated by the person himself or someone in his family. Neighbors or close friends may be asked for help. Should the sickness persist, a diviner may be consulted. The diviner himself might undertake treatment. Or he could recommend a curandero, a person believed to have received healing power from God. Relations between curanderos and patients follow a prescribed pattern, but, compared with American physician-patient patterns, they are warm and relatively emotional. Patients are received in the curandero's home. Illness is diagnosed and explained in terms of ideas and knowledge which the patient can understand. Each step of the treatment is made clear. The difference between this treatment and the cool impersonality of hospitals and professional offices often keeps Mexican-Americans from approaching physicians and other medical specialists.[5]

A complete catalogue of different health beliefs and behaviors would be long and colorful. To the outsider observing a strange society, its medical system may seem senseless or even foolhardy. Seen in their social context, however, health practices are almost always explicable and may be appropriate.

By the same token, differences within single societies are patterned and intelligible in their own settings. A course of action which would be eccentric in the middle class is natural and reasonable in a lower class milieu. Life conditions of the American poor, and the beliefs and values fostered there, produce a distinctive repertoire of health beliefs and behavior.

The diffuse nature of the association between social causes and effects makes it tedious to discuss them in any one-to-one fashion. One basic value orientation evinces itself in many separate items of behavior. And any given action is the sum of several interwoven attitudes and values. Clarity is better served by presenting the complex of behavior patterns in toto followed by description of the pattern of causes. For the present topic, this means a presentation of health care differences between middle-class and lower class Americans, supported by discussion of their sources in the lower class style of life.

Not too many years ago, the comparatively high rates of disease among the poor were considered the natural result of poor living conditions. Crowded and deteriorated housing, poor nutrition, and insufficient medical care were accepted in explanation. Medical advances and development of effective public health measures have refined the phenomenon of poverty-connected illness. It can no longer be so simply explained. Infectious diseases--tuberculosis, pneumonia, influenza, typhoid fever--have subsided. In their wake, it is apparent that other diseases not so attributable to the material environment are also associated with low-income status. Rates of degenerative diseases, particularly cardiovascular disorders, vary with socioeconomic conditions. Rheumatic fever, for example, is rare among the well-to-do, but its incidence rises as one looks down the social scale.[6] The chronic diseases (e.g., heart disease, diabetes mellitus) are relatively more prevalent among the poor.[7] Incidence of all forms of cancer is inversely related to income.[8] Cervical cancer occurs more often and causes more deaths among women of the lower classes.[9] It has been found that premature births are more frequent among lower class mothers.[10] Infant mortality is strongly associated with both low income and low occupational status.[11] Class status is also persistently associated with prevalence of schizophrenia.[12] A similar association has been documented for other diseases.

Although more vulnerable to ill health than the rest of the population, the low-income strata are likely to be more ignorant about it. They have less factual information about causes, treatment, and outcome of various diseases.[13] More to the point, they are not informed about preventive measures.[14] Curable conditions are often defined as unavoidable and incurable.[15] Dental decay and the ultimate loss of teeth, for example, are simply inevitable happenings to which they are resigned.[16] The lower class person is likelier to believe that any dysfunction, including mental disorder, has a physical cause.[17]

In the place of factual knowledge about disease, a situation-bound definition of illness appears. To the white-collar worker and those above him in the socioeconomic scale, a disease symptom, by its very existence, signals ill health. In the working class and among the poor, physical discomfort alone is not identified as illness. Only when one is incapacitated, when he cannot fulfill his daily responsibilities, is he "sick."[18]

With less known of the causes of disease, it is not surprising to find less attention given to disease prevention. A striking example of this is the handling of dental caries. It has been found repeatedly that poor socioeconomic condition is associated with fewer visits to the dentist for preventive treatment and more visits for extractions and treatment of drastic conditions.[19] This attitude on the part of adults affects children as well. Mothers are less concerned with detecting children's illnesses or taking precautions to prevent them.[20]

Treatment is sought at a relatively late

stage. The definition of "serious" illness is closely linked with a family's position in the social structure. Middle and upper class persons are likely to evaluate a longer list of symptoms as potentially serious.[21] Treatment of mental illness is likewise postponed. Occasionally, advanced mental disturbance is not treated, simply because it is not socially disruptive.[22]

There is relatively little participation in community health activities. Less is known about public health programs and resources.[23] The poor seem to be insulated from the campaigns of numerous health foundations. They have a low rate of participation in prevention programs. A British study of diphtheria immunization revealed that the participation of children was strongly related to family income.[24] Closer to home, in a U.S. study of the Salk vaccine trial, it was found that high and middle status groups were each about twice as likely to have their children immunized as lower class parents were.[25]

Lower income persons are more likely to practice self-medication. Consequently, they have small household collections of patent medicines more often than other classes.[26] When home treatment is ineffective, friends and neighbors are likely to be canvassed for advice on an ailment.[27] When persistence of illness, or a particular discomfort makes more expert treatment necessary, there is greater possibility that subprofessionals will be approached. A druggist's advice will be asked.[28] A chiropractor may be consulted, rather than a physician.[29]

Medical professionals tend to provide different treatment to different classes of patients. In large part, this is a matter of ability to pay. It is particularly true in dental care, where malfunction is not vitally related to total well-being. Some dental treatment is, in fact, cosmetic rather than medical. The straightening of teeth is very often aesthetic rather than functional. Orthodontic treatment has been found to be strongly class-related, with very little of it being done for lower classes. Similarly, the upper classes get more purely preventive dental treatment (cleaning of teeth, routine examinations, etc.).[30]

Socioeconomic classes are differentially treated also by psychiatrists and psychotherapists. One reason is the routes by which medical treatment is approached. Upper and middle class schizophrenics arrive at treatment through medical channels and most often are treated by psychotherapy. It is more often legal means which force lower class schizophrenics into hospitals. Once there, they are likely to be treated organically or to be retained in custody without treatment.[31] Even where financial capacity is ostensibly not a factor (as in public outpatient clinics) the lower classes are less often accepted for psychotherapy.[32] In such public facilities, it has been found that less skilled staff members (e.g., medical students) are more likely to be assigned poorer patients. Lower class patients are treated for shorter periods and by less intensive techniques. Finally, lower class patients are less likely to improve in psychotherapy.[33]

Withal, poverty is itself a health hazard. The poor are more vulnerable to disease and less able to cope with it.

It is reasonable to suggest that, in large part, community health programs have fallen short of success because they attack symptoms rather than causes. The particular health needs of the poor have been treated as discrete phenomena. Their sources in the structure and dynamics of poverty have not been attacked. Yet, until the social genesis of health behavior is considered, the behavior itself cannot be changed.

Ways in which the low-income stratum copes with its health problems are traceable either to the material situation of poverty itself, to the social structure of poverty, or to aspects of the life outlook of poverty--the ideals, values, and beliefs to which the poor man adheres.

ECONOMIC SOURCES OF HEALTH BEHAVIOR

Elaborate discussion of direct effects of poverty on health care is unnecessary--they are what one would expect. People

who have little money, no savings, and scant hope of improving their finances do not spend money to insure perfect health. They consider themselves sufficiently "healthy" so long as they are able to keep working and bringing in the little money they can earn.

This immediate relationship between income and the seeking of health services points up sharply the relativity of health definitions. When income is more than sufficient for needs, one's list of "desirables," even of "necessities," can include many values several steps removed from mere survival. One can insist on freedom from physical discomfort (let alone pain), can take measures to provide for future health and the prolongation of life, and can afford to think of preventive examinations as routine. On the other hand, when income is uncertain and not always enough to cover rent and food, "health" is understandably likely to be defined as the ability to keep working. Treatment is postponed until disability is threatened. In reasonable sequence with this economic definition of health, a family's wage earner often gets medical care which other members do without. For example, Koos quotes a lower class housewife: "If something was wrong with my husband, we'd get it fixed right away. He earns the money and we can't have him stop work. I can drag around with my housework, but he can't drag around and still earn a living." [34]

Beyond their effect on definition of health, the hardships of poverty seem to nudge health downward in the hierarchy of values. When a household is operating with a minimum of material necessities, first aspirations are for concrete, physical improvement--for a better place to live, for more and better household equipment, even for some luxuries. Health comes further down the list. Koos reports the explanation of a woman who had left a serious internal disorder uncorrected for 2 years: "I wish I could get it fixed up, but we've just got some other things that are more important first. Our car's a wreck, and we're going to get another one. We need a radio, too, and some other things. If my husband's job holds out, we'll get them, and then I'll have it done, if it doesn't cost too much...but it's got to wait for now--there's always something more important." [35]

STRUCTURAL INFLUENCES ON HEALTH BEHAVIOR

The structure of society, and the distances--in terms of communication and understanding--between classes, are accountable for much failure in getting health care to the very poor. Their exclusion from society's mainstream of activities acts with awareness of that exclusion to prevent much care which would be free or well within their ability to pay.

The poor do not have or use as many sources of information about the world around them as other classes. They read newspapers less and pay less attention to news and information programs in other media. Standing aside from the usual communication channels, they fail to learn of routinely available services or of periodic campaigns aimed at specific health problems. [36]

Lower income people do not participate much in the organized voluntary structures which tie so many middle-class people to a community. Parent-Teacher Associations get little attention from them. Organizations for less tangible purposes--civic associations, voters' organizations, etc.--get even less. Nor, failing this kind of membership, do they organize among themselves. In other words, they lack contact not only with the community but among themselves. It is a lack disastrous for routine attempts to draw them into such activities as immunization and X-ray campaigns. [37] That this isolation is vital is clear when we learn that poor people who do participate more in the community also have more information about health, are more concerned about preventive measures, and take greater part in health campaigns. [38]

Most Americans know and accept the sociological idea of society as a layered system. Our ideology denies the less democratic implications of such stratification. But, regardless of fact or ideology, people are evaluated and reacted to partly

as a result of their places in the social structure. All of us are aware, more or less continuously and more or less sharply, of such evaluation of ourselves. It is an awareness which always affects out interactions with people either above or below on the scale.

People at the bottom, sociologically sophisticated or not, know that wealthier, better educated people are likely to be more or less contemptuous of them. Worse, they sometimes adopt those attitudes toward themselves. And so is constructed one more stumbling block in the way to efficient health care for the poor.

Awareness of social distance is probably one of the causes of distrust of physicians among low-income people. Definitely, the distrust of doctors is linked to low rates of participation in health programs. Feelings about social distance can also be discerned in the poor man's preference for consulting a chiropractor or a druggist rather than the more educated, therefore more distant, medical doctor.

However, it is in clinic attendance and community program participation, rather than in commerce with individual practitioners, that the disaster of the poor man's seeing himself in this way is clearest. People who feel themselves poorly evaluated by clinic personnel are less cooperative patients and use clinics less. They are less accessible to health information and education efforts of clinic personnel.[39]

Less obvious than some of these results of the place of the poor in society is the fact that their isolation and distance from the active community make it almost inevitable that their own attitudes will be unfavorable to "scientific," preventive health patterns.[40]

LIFE OUTLOOK AND HEALTH BEHAVIOR

Three aspects of the low-income outlook on life seem to impinge with particular sharpness on health behavior: (1) attitudes of fatalism--helplessness, combined with relatively slight future orientation, (2) preference for particularistic and personalized relationships (distinguished from more impersonal and formal exchanges), and (3) more concrete, materialistic modes of thinking and talking.

The diffuse fatalistic feeling of powerlessness which informs so strongly the relationships of the poor to the rest of society is embodied most pathetically in resignation to illness. It is often regarded as unavoidable ("If you are going to get sick, you are going to get sick, and there's no use worrying about it"[41]). For example, one finds very often the idea that total loss of teeth is ultimately inevitable. The natural consequence is less attention to preventive measures. It is fairly common to learn that a person has had some or all of his teeth removed in preference to paying for their restoration to working condition. It is an attitude which, held by parents, affects the care of children. Less educated mothers have been found not only more fatalistic about illness but less concerned about protecting children's health.[42] When such fatalism is accompanied, as it often is, by a foreshortened time orientation, medical treatment is even more problematic. Preventive health measures and courses of treatment which are spaced out in time are not congenial operations to the person who thinks primarily in terms of the present.

Habituation to the person-to-person relationship--dealing with people primarily as people rather than functionaries or role performers--handicaps one for more impersonal action. It often leads to the conviction that bureaucratic situations are cold, unfeeling, and belittling of people involved. It results in avoidance of such situations.

Most middle-class persons have learned to accept impersonal, assembly-line treatment. Depth and warmth, "the human touch," are dispensed with as part of the price for expert, efficient service. Lower status people are less able to do so. In the health area, this means that they prefer "the bedside manner" and the practitioner who seems concerned for the patient rather than simply interested in the disease. One result of this preference is the tendency to consult semiprofes-

sionals rather than fully trained physicians. Druggists are more accessible, more likely to be on familiar footing with customers, and more likely to interact on a friendship basis than are medical doctors. "He's more than just a drug-seller; he's a good friend."[43] Chiropractors are often preferred to physicians for somewhat similar reasons. They are seen as less hurried, more sympathetic, and available when needed rather than "by appointment only."[44]

Repugnance for detached, distant relationships is probably also the partial source of lower class distrust of hospitals. The efficiency of the modern hospital, sometimes resembling that of a hotel, often is maintained by an impersonal, psychologically "cool" bureaucracy. It is easy to feel that "they" don't care about patients as people and to be not only affronted but frightened. The result is often postponement of needed hospitalization.

The patterns of thought and speech prevalent in the lower classes tend to make them immune to some of the preferred techniques of psychotherapy. They are, to begin with, less verbally oriented than better educated people. Their interpersonal exchanges involve smaller amounts of symbolic, linguistic behavior. Their habitual language is itself concentered on material, concrete matters. They lack the experience in verbalization and reflection which is a sine qua non of psychoanalysis and similar techniques. In consequence, they are often rejected out of hand by therapists. Or, accepted, they fail to benefit.

HEALTH SERVICES FOR THE INDIGENT

Large numbers of the poor receive public assistance. In some States and localities substantial medical care is made available to those eligible for assistance. Medical help is sometimes provided people who, except for inability to pay for health care, are otherwise self-sufficient.

Thoughtful observers have pointed out that these programs vary greatly in their conformity to standards for good medical care and in their contribution to achievement of welfare aims.[45] Scope and quality of service vary from place to place. Health needs of equal urgency are provided for unequally. All too often, inadequate budgets, absence of quality controls, and faulty coordination between health and welfare departments affect provision of care. Continuous relationship between a patient and his physician, an essential of good medical care, is usually impossible when care is tied to the intermittent condition of welfare eligibility. The vital part which complete, continuous health care of high quality could play in reduction of economic dependency has thus been forestalled by the nature of medical programs themselves.

SUMMARY AND IMPLICATIONS

Economic deprivation is associated in America with higher rates of disease and, for some diseases, higher mortality. The difference appears connected with relative social isolation, and with adherence to inhibiting beliefs and attitudes, as well as with material poverty. To date, public assistance programs in most States have not basically affected this situation.

Corrective measures, because they will involve structural and behavioral changes, will necessarily be slow. An obvious requirement is development of better coordination between public health and welfare operations.[46] The recent Social Security amendments ("medicare") will expand the numbers of people eligible for federally supported health benefits and the amount of care which they may receive. Success of this and future efforts to improve the health of the economically deprived will be significantly affected by the extent to which existing knowledge of health behavior is used and extended. It may be necessary, for example, not only to make health care accessible, but actually to carry it to the neighborhoods and doorsteps of the poor--in other words, to make a present of it rather than simply being willing to supply it. It must be made available in such a way that one need not choose between continuous, pre-

ventive health care and other goods. Findings of communications research should be brought to bear on the problem of informing the poor of facts of both good medical care and the services to which they have a right. Most important of all, a community's poor must be psychologically and socially absorbed into its structure, so that health care becomes their unquestioned right rather than something which is dispensed as charity and sought reluctantly.

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State Public Assistance Legislation 1963 and 1964

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STATE LEGISLATURES which convened in 1963 and 1964 gave consideration to many proposals designed to extend and improve their public assistance programs. Although some failed of final passage, a significant number of constructive laws were enacted affecting State programs of financial assistance, medical care, and social services to the needy for which Federal financial participation is available under the public assistance titles of the Social Security Act.

The bulk of these enactments clearly reflected the impact of the Public Welfare Amendments of 1962, enacted by the 88th Congress to encourage the development of socially constructive State programs, with primary emphasis on the provision of welfare services designed to prevent or reduce dependency and to help recipients to attain goals of self-support and self-care.

By the end of 1964 substantial progress had been made toward implementation of the new legislation. In many instances States found it possible to make the necessary program changes simply through administrative action. In other cases, the path was cleared through State legislation increasing the basic statutory authority of their State welfare agencies or making other types of change in existing law.

Social Services

As an incentive to States to make their public assistance programs a more constructive force by increasing and intensifying their social services, the 1962 amendments increased the Federal share of the cost of providing certain services to recipients from 50 percent to 75 percent. Federal participation at this level was, however, made contingent upon a State's meeting a number of new plan requirements, including the provision of certain minimum services to all recipients. Among the State laws enacted in relation to the provision of services were those of Georgia, which establish a division for children and youth in the Department of Family and Children's Services; Alaska and New York laws making mandatory the requirement of a plan for each child recipient of aid to families with dependent children (AFDC); the laws of California and Maryland redefining the purpose of public welfare services; the laws of Idaho, Illinois, Minnesota, New York, and Washington extending the State and local agencies' responsibility for providing or coordinating welfare services; and the New York law authorizing the recruitment, utilization, and training of volunteers to assist in providing services in public welfare districts.

Training of Welfare Personnel

To encourage States to provide more funds for the training of persons employed or preparing to work in State or local welfare agencies, the Public Welfare Amendments of 1962 authorized an increase, under certain conditions, from 50 percent to 75 percent in the Federal share of expenditures for such purpose. The legislatures of California, New York, and Washington granted new authorization to

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their State welfare departments for expenditures for training and otherwise furthering the professional competence of their employees.

Pilot and Demonstration Projects

The 1962 amendments also authorized Federal financial participation in experimental, pilot, and demonstration projects developed by States and deemed likely to further the objectives of the federally aided public assistance programs. This amendment, which appears as section 1115 of the Social Security Act, includes a provision for the waiver of certain plan requirements to the extent the Secretary of Health, Education, and Welfare may find necessary for the success of the project. In 1963, California, New York, Washington, and Florida enacted legislation granting authorization for conducting and financing such projects, and in 1964, Georgia and Louisiana enacted similar legislation.

AFDC-UP

Another of the 1962 amendments extended to June 30, 1967, a 1961 temporary provision authorizing Federal financial participation in payments to needy families where the children are deprived of parental support or care because of the unemployment of a parent. In 1963, the legislatures of Kansas, Michigan, and Ohio granted authority for such extension of their AFDC programs, while in California, Washington, and Illinois, which already had such a program, the statutory definition of unemployment was liberalized. In 1964 the Michigan AFDC-UP law was amended by eliminating certain restrictions relating to the parent's eligibility for unemployment compensation and by adding certain requirements regarding refusal or abandonment of work.

Community Work and Training Programs

An important innovation of the Public Welfare Amendments of 1962 was the authority for Federal financial participation (until June 1967) in the cost of local community work and training programs for unemployed AFDC caretaker-relatives, administered by or under the supervision of a State agency and meeting certain statutory conditions and requirements. The following State legislatures provided statutory authority in 1963 and 1964 for the development of such community work and training programs: California, Delaware, Illinois, Kansas, Michigan, Ohio, Pennsylvania, and Washington.

Setting Aside Income for Future Needs of Child

Another 1962 amendment designed to prevent future dependency by providing incentives for public welfare recipients to improve their condition was one permitting States in their programs of AFDC to consider income as not available for meeting current needs to the extent that it is set aside for the future identifiable needs of a child. Laws to implement this provision were enacted in 1963 in Alaska, Illinois, Minnesota, New York, Oregon, Texas, and Washington. Of these, the laws of Minnesota, New York, Oregon, Texas, and Washington permitted the setting aside of income of the child only and not that of other members of the family.

Extension of AFDC to Second Parent

Maine, Oregon, Pennsylvania and Washington took legislative action to implement another of the 1962 amendments to Title IV of the Social Security Act. This amendment authorized Federal financial participation in costs of money payments and medical care provided to meet the needs of the spouse of the unemployed or incapacitated parent with whom an eligible child is living, provided the spouse is living with the child's parent.

Foster Care of Dependent Children

A temporary amendment to Title IV of the Social Security Act, enacted in 1961, authorized Federal matching funds for State expenditures on behalf of certain children receiving AFDC who, as a result of a judicial determination that to continue to live in their own homes would be

adverse to their welfare, have been placed in foster family homes. In 1962, this temporary provision was made permanent and, for the period from October 1, 1962, to June 30, 1964, was broadened to include children receiving care in nonprofit child-care institutions. In 1964 Congress extended the effective period covering such child-care institutions until June 30, 1967.

State laws authorizing foster care for child recipients of AFDC were enacted in Alaska, Georgia, Kansas, Michigan, Minnesota, Missouri, New York, Tennessee, Texas, and Washington. Alaska's law extends the authority to cover children in foster family homes only, while in the other nine States the authority extends also to children in child-care institutions. In addition, Vermont, which already had authority to pay for the care of children living in foster family homes, amended its law to extend coverage to care in a child-care institution.

Protective Payments

States also enacted laws in connection with another of the 1962 amendments, which authorized Federal financial participation in the payment of assistance grants to a nonrelative payee in situations where the parent or relative-caretaker of an AFDC child is so incapable of managing funds that the child's welfare is adversely affected. Where this situation is clearly demonstrated and certain other statutory requirements are met, State welfare agencies may, without recourse to the court, appoint someone interested in the welfare of the recipient to receive and manage his assistance payment. Laws authorizing welfare departments and agencies to make such protective payments on behalf of AFDC recipients were enacted in California, Minnesota, New York, North Carolina, Oregon, Texas, and Washington.

Exemption of Earned Income in Old-Age Assistance

Under provisions of the 1962 amendments, States may, in their old-age assistance programs, disregard certain earned income of a recipient up to a certain maximum described as "of the first $50 per month . . . not more than the first $10 thereof plus one-half of the remainder." Louisiana, Missouri, Vermont, and Washington implemented this provision in 1963 through amendment of their old-age assistance laws, while Kansas and North Dakota included it in their legislation authorizing a combined public assistance program under the new Title XVI.

Blind Recipient's Plan for Self-Support

Another provision for income exemption contained in the 1962 amendments was designed to encourage the needy blind in their efforts to become self-supporting. It requires that, in the case of a blind recipient with an approved plan for achieving self-support, there must be provision for disregarding, for a period not to exceed 12 months, such amounts of income and resources as may be necessary for the fulfillment of the plan. In 1964, Congress modified this provision to permit States, if they choose, to extend this period for an additional 24 months.

Specific legislation to implement this new requirement was enacted in the following States: Alabama, California, Colorado, Illinois, Indiana, Kansas, Minnesota, New York, North Dakota, Ohio, Oregon, Vermont, Virginia, Washington, and Wisconsin. In addition, the legislatures of Nevada and Guam enacted enabling legislation covering this new requirement, but in generalized language directing the disregarding of such income and resources in aid to the blind as is required by Federal law.

Consideration of Expenses of Earning Income

Another of the 1962 amendments designed to encourage recipients in their efforts toward self-help was one which requires that, in the determination of need in all federally aided public assistance programs, States must give consideration to all expenses reasonably attributable to a recipient's earning of income. In only three States--Illinois,

Oregon and Washington--was it found necessary to enact legislation as a basis for implementing this new requirement.

Simplification of Categories (Title XVI)

Under the provisions of Title XVI, which was added to the Social Security Act by the 1962 amendments, States may file with the Department of Health, Education, and Welfare a single plan consolidating their programs of assistance for the aged, blind, or disabled, and medical assistance for the aged. Certain benefits may be derived from such a plan, including administrative simplification and an increase in Federal financial participation in certain medical care payments.

During 1963 and 1964 the legislatures of Illinois, Kansas, Maine, New York, and North Dakota provided the statutory base needed for conversion of their separate programs into a single Title XVI program.

OTHER STATE LEGISLATION

In addition to implementation of the 1962 amendments, State legislatures enacted many new laws and amendments, refining, extending, and improving the public assistance provisions in their laws.

Medical Assistance for the Aged

During 1963, 10 States enacted legislation providing a permanent statutory base for MAA programs. These States were: Florida, Indiana, Kansas, Minnesota, Nebraska, Nevada, North Carolina, South Dakota, Washington, and Wyoming. In addition, Vermont extended the expiration date of its MAA law from June 30, 1963, to June 30, 1965. In Texas, a proposed constitutional amendment for MAA authorization was submitted to the voters and ratified in 1964.

Other States, including Connecticut, Oregon, New York, Pennsylvania, and South Dakota, broadened and improved their existing MAA laws through various amendments relating to such matters as eligibility, scope of services, or method of State payment for care.

Medical Care in Other Programs

Amendments to laws authorizing medical care and services to recipients of one or more public assistance programs were enacted in California, Georgia, Maine, Massachusetts, Missouri, Nebraska, Nevada, New York, North Carolina, Oregon and South Dakota. Most of these laws were designed to broaden the eligibility for or the scope of medical care and services provided to recipients. In North Carolina, for example, a section of the law authorizing hospitalization for OAA, AFDC, and APTD recipients and their spouses was expanded to include authorization for inpatient and outpatient services and for necessary drugs. The range of these State laws covered many other matters related to the provision of medical care, such as the Georgia enactment which relieved counties of the requirement for paying part of the cost of medical care benefits in AB, APTD, and AFDC, thus making these laws consistent with the State OAA law.

Age of Child in AFDC

In 1963 and 1964, Federal financial participation was available in AFDC with no limitation or prohibition as to the age of the child other than that he be under 18. Six States with more restrictive age limitations enacted legislation to give greater breadth of coverage to needy children under their programs. These States were: California, Georgia, Illinois, Nebraska, North Carolina, and Texas.

By virtue of Public Law 88-641, enacted by the Congress late in 1964, the age restriction in AFDC was liberalized so as to extend the age of eligibility to 21 in the case of children attending high school or a vocational or training course. As all but a few State legislatures had concluded their 1964 sessions, no State laws were enacted during that year to provide for such extension of their existing statutory authority.

Refusal to Accept Employment, Training, or Medical Treatment

Three States enacted laws whereby the acceptance or refusal to accept employment or training services (Illinois and Washington), or medical care (New York) by an applicant or recipient will under certain circumstances affect receipt of aid under various of the public assistance programs. The application of these provisions is governed by various criteria as, for example, whether there was good cause for the individual to refuse employment or training or whether there exist circumstances under which his acceptance would result in depriving the dependent child of care, supervision, or protection essential to the child's welfare.

Other Provisions Relating to Eligibility

Scattered throughout the State legislation during this period was a miscellany of other provisions relating to eligibility for public assistance. In California's aid to the disabled program, for example, the need for regular care, either in the form of physical assistance or continuous supervision, was eliminated as a requirement, and eligibility can now be established by showing that the permanent impairment substantially precludes the person from engaging in useful occupations within his competence, including homemaking.

Other liberalizing amendments included removal of a statutory limitation which restricted eligibility for APTD in Maine to persons under the age of 65, and the deletion of a provision in Florida's APTD law which declared a person ineligible if he had a spouse, parent, or children residing in the State who, jointly or individually, were financially able to provide him with reasonable subsistence.

Income and Resources

Many of the State enactments dealt with the income and resources which must be taken into account in determining an applicant's or recipient's eligibility or need for public assistance. The majority of these enactments took the form of liberalizing amendments to the States' OAA and MAA laws, and included increases in such items as: income of recipient (Connecticut, Michigan, Oregon), amount of life insurance allowable (Georgia), amount of child's earned income to be exempted in determining the resources of an aged parent (Massachusetts). Both Massachusetts and New York increased the limits of income and resources allowable to a MAA recipient who is not living in a nursing home or other type of medical institution.

Several of the State laws related specifically to property owned or occupied by applicants and recipients of public assistance. Among these were the enactments of Alabama and California relating to their aid to the blind programs. The Alabama law provided that an applicant for AB may retain real or personal property, regardless of its value, if it provides him with a home; while the California law eliminated the policy of attributing an amount as income when a recipient of AB owns and occupies his home. Of interest also is the 1963 Georgia law which provides that any resources received by a recipient of public assistance from the disposition of property due to governmental action is to be disregarded in making eligibility determinations.

Limitation on Amount of Assistance Payments

Legislation relating to limitations on the amount of monetary payments to recipients of public assistance was enacted by 14 States: Alabama, Alaska, Arkansas, California, Delaware, Florida, Illinois, Massachusetts, Michigan, Missouri, Nebraska, Oklahoma, South Dakota, and Vermont. For the most part, the new laws increased the statutory maximums on monthly grants in one or more of the public assistance programs in flat amounts ranging from $5 to $25 a month, as in the case of Delaware's OAA program, where the maximum was raised from $75 to $100. In addition, by action of the Texas electorate upon a proposed amendment to their State constitution, dollar amount limitations on monthly

grants to recipients of OAA and APTD were eliminated from the constitution.

The amendatory legislation of South Dakota was of a somewhat different nature, in that it entirely removed the statutory maximums on the amount of assistance grants to individual recipients and, in lieu thereof, substituted certain formulas for controlling maximum expenditures for each of the several programs of categorical assistance.

Illinois also changed its statutory method for controlling the amount of assistance grants in AFDC. Under the new law, maximums for monthly assistance payments are established on the basis of the number of children in the family group, ranging from $80 for one child and a relative up to a ceiling of $220 for 10 or more children and a relative. The law specifically provides that these maximums are not to include rent, utilities, or extraordinary medical costs, and that they may be exceeded in certain circumstances.

Residence

A few States enacted legislation concerning the minimum duration of residence in the State which is required for eligibility for public assistance. Notable among the liberalizations were changes in the laws of California and Illinois. In California, durational residence was entirely eliminated as a statutory requirement for participation in the aid to the blind program, and was also eliminated in the aid to the disabled program in those cases where the disability occurs while an individual is residing in the State. Illinois similarly liberalized its APTD law by excepting from the 1-year duration residence requirement those persons who become permanently and totally disabled while residing in the State, provided residence in the State has been continuous and uninterrupted from the time of the accident or injury. In Texas, certain durational residence requirements as to eligibility for AFDC, OAA, and APTD were eliminated from the language of the State Constitution through adoption by the electorate of a constitutional amendment.

Liens, Recoveries, and Assignments

Of the 13 States which enacted laws regarding liens, recoveries, and assignments on the property of public assistance recipients, some were of a restrictive and some of a liberalizing nature.

Among the States which liberalized their laws in this area were Alabama, California, and West Virginia. The Alabama law provided that the cost of hospitalization or other medical care or other services furnished to a recipient of AB shall not constitute a lien on his property or personal effects. The California legislature provided that the cost of hospitalization furnished by a county and any judgment obtained against a recipient to obtain repayment of such costs shall not constitute a lien against the real property of a recipient, nor shall a lien be taken thereon. This provision, which now applies to all categories of assistance, formerly existed only with respect to personal property of a recipient of OAA and AB. The West Virginia enactment eliminated from the OAA law a requirement that a recipient grant a lien to the State upon real or personal property as a condition to receiving assistance.

Legal Representatives

During 1963 and 1964, six States enacted legislation concerning assistance grants to designated or legally appointed representatives of public assistance recipients. These States were: Alaska, California, Florida, Georgia, Kansas, and New Jersey.

The Georgia and Kansas statutes, both of which provide for the judicial appointment of a personal representative to receive and manage the assistance grant of a recipient who is unable to care for himself and his money, specifically provide that employees of the welfare department are ineligible to receive such an appointment.

Florida's legislature enacted an unusual law declaring that the court appointment of a guardian for an incompetent recipient of public assistance is unnecessary where the incompetent is living in a household with an adult member of his family.

Location of Parents and Other Relatives

Nine States enacted legislation to facilitate the location of certain relatives responsible for the support of dependents. The legislation of California, Minnesota, Texas, and Washington is concerned with the location of parents only; whereas, in Arkansas, Connecticut, Missouri, Vermont, and Virginia, it relates not only to deserting parents but also to "other persons liable for the support of dependents."

Typical of the substantive area covered by such legislation are the enactments in Arkansas, Connecticut, Vermont, and Virginia, which are substantially identical, and which authorize the State welfare departments to request, and direct all State departments and agencies to furnish information as to the identity and whereabouts of deserting parents and other persons liable for the support of dependents. In addition, these laws authorize the State welfare department to make such information available to public officials and agencies of their own and other States seeking to locate such persons in order to enforce their liability for support.

Relatives' Responsibility for Support

In 1963 and 1964, the legislatures of Alabama, California, Georgia, Illinois, Massachusetts, and Washington enacted laws concerning the responsibility of relatives for furnishing support to recipients of public assistance. These laws ranged in approach and scope from the Alabama law relieving relatives of recipients of AB from any responsibility for support to an amendment to the Illinois Public Assistance Code which established the order of priority in which relatives will be called upon to furnish support, and the Washington statute which directs the State Welfare Department to establish a scale of suggested minimum contributions of a parent to furnish support for a dependent child.

Fraud and Misuse of Funds

Among the State legislatures which took action for the control of fraud and the misuse of funds by recipients of public assistance were New York, which made it a misdemeanor for the payee of an AFDC allowance for the benefit of a child to misuse such an allowance willfully, and Ohio, which amended its OAA, APTD, and AFDC laws to provide that failure to report the possession of property or income in excess of the allowable amounts shall be regarded as prima facie evidence of an intent to defraud.

Legislation in this general area was also enacted by Connecticut, Oregon, Texas, and the Virgin Islands.

The "Growth of American Families" Studies

ARTHUR A. CAMPBELL*

THERE HAVE BEEN two nationwide interview surveys of family planning in the United States. They are known as the Growth of American Families (or GAF) Studies, and were conducted in 1955 and 1960 by the Survey Research Center of the University of Michigan and the Scripps Foundation for Research in Population Problems, Miami University, Oxford, Ohio.[1]

These studies were stimulated in part by the unexpected maintenance of high birth rates in the postwar period. In 1946 and 1947 the birth rate rose rapidly to the highest level it had reached in the preceding quarter of a century. This "baby boom" was not entirely unforeseen, because a similar, though less extreme, rise occurred after World War I. What was unexpected was the length of time the birth rate remained at 24-25 per 1,000 population.

The birth rate dropped steadily during the 1920's and early 1930's from a high of 28 in 1920 to a low of 18 in 1933, and stayed in the 18-19 range during the remainder of the 1930's. Roughly parallel movements had occurred in other industrially developed countries throughout the world, and demographers had become accustomed to the generalization that as industrialization and urbanization proceed, fertility declines. A number of highly plausible explanations were offered to account for this widely observed relationship, and a body of economic thought developed to deal with the problems that presumably would be presented by stable or declining populations. The possibility that fertility might someday rise was not considered seriously.

The prevailing opinion was expressed explicitly in population projections prepared for the Census Bureau by P. K. Whelpton in 1946 and 1947. These projections were based on the assumption that the postwar spurt in the birth rate would be short-lived and that fertility would eventually decline to a level at or near the rates observed during the late 1930's. In a very short time, of course, this assumption was shown to be inaccurate. By 1950, the actual population had reached 151 million, but the highest population projected for this year was only 148 million.

This head-on collision between fact and theory had a very stimulating effect on demography and led to some exciting and useful innovations. In particular, P. K.

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[1]The results of the 1955 study are reported in Ronald Freedman, Pascal K. Whelpton, and Arthur A. Campbell: Family Planning, Sterility, and Population Growth. McGraw-Hill, New York, 1959.

The results of the 1960 study will appear in Pascal K. Whelpton, Arthur A. Campbell, and John E. Patterson: Fertility and Family Planning in the United States. To be published by the Princeton University Press.

Whelpton was the first to revise the traditional modes of fertility analysis with the development, during the early 1950's, of the cohort approach.

RECENT TRENDS IN FERTILITY

In essence, the cohort approach studies fertility as a cumulative process, making explicit use of the obvious fact that what happens early in the childbearing period affects what happens later. It follows the reproductive histories of women from the beginning to the end of the childbearing period.

First of all, cohort analysis showed that many women who were old enough to have children in the 1930's did not have them then but postponed them until the postwar period. Part of the "baby boom" represented their relatively late childbearing.

Cohort analysis also revealed that the age at which women were having children had declined considerably during the early postwar period. This resulted in the heaping of births in the younger childbearing ages, which, of course, raised the birth rate substantially. It was not clear, however, whether the women who were doing their childbearing at younger ages would go on to have more children so that on the average they would have more than the women who preceded them in childbearing, or whether they would soon curtail their fertility and have the same number. Obviously, if their completed fertility were going to be no higher, their current fertility would remain high for only a few years and then fall to previously observed low levels.

One of the principal objectives of the first GAF Study of 1955 was to find out how many children women then in the reproductive years of life expected to have. In addition, the survey was designed to obtain information on couples' ability to have children (their "fecundity") and on their control of fertility. The sample consisted of 2,713 white women 18 to 39 years old who were married and living with their husbands. They represented approximately 17 million wives throughout the United States.

The second GAF Study of 1960 was designed, in part, to see how accurately the wives interviewed in the first study had predicted the number of births that women like themselves would have. However, the same women were not interviewed in both studies. Instead, an independent sample was drawn for the 1960 study. The 1960 sample included several groups:

2,414 white wives 18-39 years old (the same definition as the 1955 sample)

572 white wives 40-44 years old (included to check on the childbearing of women who were 35-39 in 1955)

66 white women 23-44 years old who were married in 1955, but widowed or divorced in 1955-60 (to check on the childbearing of women who were eligible for the 1955 study, but were no longer married)

270 nonwhite wives 18-39 years old (to get the first nationwide information on family planning for nonwhite couples)

The 1955 study showed that the young women expected to have larger families, on the average, than earlier cohorts of women. This rise was not coming about from an increase in the proportion of couples with "large" families (say, six or more children), but from a decline in the proportion of couples with no children or only one child and an increase in the proportion with moderate-sized families of two to four children. It was clear that childlessness had lost whatever appeal it once had, but at the same time people did not want unusually large families.

What does this mean in terms of national averages? Fertility reached a low among women in the 1909 cohort (i.e., women born in 1909). By the time these women had completed their fertility, they had borne an average of 2,230 children per 1,000 women. It is not yet known which of the cohorts now reproducing will

achieve the highest fertility, but it appears that the 1935 cohort will be close to the peak with about 3,350 births per 1,000 women by the end of the childbearing period, which they will reach in the 1980's. This will mean an increase of 50 percent in completed fertility between the 1909 and 1935 cohorts. Although this increase represents only one child per woman, on the average, it has already brought about a substantial rise in the rate of growth of our population.

The 1960 GAF Study fully confirmed the birth expectations collected in 1955. Over the 5 years, 1955-60, women in the reproductive ages had about as many children as wives interviewed in 1955 said they expected to have during this period.

THE USE OF CONTRACEPTION

It has been observed that women have been able to make useful predictions of the number of children they will have. How do they control their fertility? In presenting the findings on this topic, attention will be confined to white wives 18-39 years old, the group that is common to both the 1955 and 1960 studies.

First, it is important to recognize that a large majority of married couples have or expect to have some form of limitation on their fertility.

The 1960 study revealed that:

81 percent of the couples had used some form of contraception (including rhythm);

6 percent expected to use contraception;

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87 percent had used or expected to use contraception;

10 percent had not used contraception and did not expect to do so, but were below normal in their physiological capacity to have children (subfecund);

1 percent were not subfecund and intended never to use contraception, but the wife reported that she regularly douched within one-half hour after intercourse, a practice that reduces the probability of conception;

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98 percent had some form of limitation on their fertility, whether intentional or unintentional, or expected to use contraception at some time in the future;

2 percent had no limitation on their fertility and intended never to use contraception.

In other words, some form of fertility limitation is nearly universal in the United States. Values are consistent with practice in this area of married life, for research has shown overwhelming approval of the idea that couples should exercise some control over the number of children they have.

The proportion of couples who have used or intend to use contraception form a clear majority of every major religious and socioeconomic group, but the size of this majority varies. For example, the study showed it is 90 percent for Protestants and 80 percent for Catholics. It is 93 percent among wives with a college education and 72 percent for wives who never went beyond grade school. What causes these variations? The main factor responsible is the wide differences among socioeconomic groups in when they begin using contraception. In certain groups, it is customary for couples to delay using contraception until relatively late in the process of family growth. The longer couples put off using contraception, the more likely they are to become subfecund before they feel the need to begin using contraception.

Delay in using contraception was shown to be most common among the poorly educated. For example, among grade-school educated wives who have been pregnant three times, only 18 percent began using contraception before the first pregnancy. The comparable proportion for college wives is 55 percent. By the time they had had three pregnancies, 76 percent of the grade-school wives had

begun to use contraception (or their husbands had), and most of the remaining 24 percent were subfecund and would probably never have to use contraception. By the time the college wives had three pregnancies, however, 92 percent had begun using contraception.

A similar explanation accounts for most, though not all, of the difference between the proportions of Protestants and Catholics who have used or will use contraception (90 and 80 percent for the two religious groups, respectively). The Catholics begin contraception later and more of them discover fecundity impairments before the time when they would begin use.

There is evidence that couples are beginning to use contraception earlier. For example, the proportion using contraception before the first pregnancy increased from 34 percent in 1955 to 38 percent in 1960. Also, the proportion of couples who already had used contraception by the time the wife was 18-24 years old increased from 68 to 78 percent in this 5-year period. Therefore, the younger cohorts now in the childbearing period can be expected to have higher proportions who eventually use contraception than some of the older cohorts.

The trend toward earlier use of contraception has already brought about a rise in the proportion of users in the 18-39 group as a whole. In 1955, 70 percent of white couples with wives 18-39 years old had already used contraception. By 1960, the comparable proportion was 81 percent. On the basis of the intentions expressed by the wives in the 1960 study, it is estimated that by 1965 the proportion of users will be even higher--about 85 percent.

HOW FAMILIES ARE PLANNED

As noted previously, a large majority of white couples try to exercise some control over their fertility by using contraception. However, they vary greatly in when they begin use and in how successful their efforts are. This section will describe in broad outline how couples use contraception to plan their families.

First of all, nearly two out of three newlyweds do not start using contraception before the first conception. In most cases, this is because they want to have a baby as soon as they can. Most of those who do begin contraception before the first pregnancy stop using it and conceive only 8 or 9 months later than other couples. The first child usually arrives less than 2 years after marriage.

After the first birth, the typical couple wants to have another child fairly soon. Although most begin to use contraception before the second child comes along, they still feel no strong pressure to avoid conception. They may omit contraception occasionally or fail to use it properly.

This casual approach to family planning is fairly prevalent until the couple has the desired number of children. It helps to account for the fact that over half the couples in our sample had pregnancies that were not intended to occur when they did. After they have had the two, three, or four children they want, however, most couples become more careful. Usually this means that they use contraception more regularly.[2]

By the time the wife is between 25 and 30 years old, the majority of couples consider their families complete, but they still have an average of about 13 to 16 years of potential childbearing ahead of them. Even though they now try to use contraception regularly, some couples do have unwanted conceptions. But most manage to avoid having more children than they want.

How successful are couples in controlling their fertility? Success can be measured in a number of ways. It might be noted that 18 percent of the couples had had accidental conceptions (i.e., they

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[2]These are among the most important findings of the Princeton Study. See Robert G. Potter, Philip C. Sagi, and Charles F. Westoff: "Improvement of Contraception During the Course of Marriage," Population Trends, vol. 16, no. 2, November 1962, pp. 160-174.

occurred while contraception was being used always) or that 54 percent had had conceptions that were not intended to occur when they did. But a more important measure of success is whether or not the couple has avoided unwanted pregnancies--that is, pregnancies that were not wanted either when they occurred or later. To get at this, each wife with two or more births was asked whether she or her husband had wanted another child at any time shortly before their last conception occurred. If one or both partners did not want any more children, and if the conception was not deliberately planned by stopping contraception, then the couple was classified as having excess fertility.

Seventeen percent of the white couples in this study are classified as having excess fertility. The comparable proportion for nonwhites is 31 percent. Among whites, couples with excess fertility have 3.7 births, on the average, and expect to have 4.1 altogether. Not all of the couples with excess fertility have or expect unusually large numbers of births: 18 percent have only two births, and 33 percent have three. In terms of expectations, 14 percent expect two births and 31 percent expect three. Thus, nearly half of the excess fertility couples expect no more births than the average white couple. Only a minority of 26 percent expect five or more births.

Excess fertility is most prevalent among couples in the lower socioeconomic categories. The greatest contrast is found when couples are classified by the wife's educational attainment: 11 percent of the college group have excess fertility, compared with 32 percent of the grade school group. Differences in husband's income are also related to the prevalence of ineffective family planning: among couples with husbands earning $10,000 or more annually, the proportion with excess fertility is 15 percent; among those with husbands earning less than $3,000, it is 21 percent.

Not only do the lower income groups have relatively more couples with excess fertility, but the degree of excess fertility is most severe among them. For example, the percentage by which the number of births expected exceeds the number of children wanted is 70 percent among couples with the husband's income under $3,000, but only 27 percent if his income is $10,000 or more. This means that most of the excess fertility couples in the low income group have two or more unwanted children. The excess in the high-income group is more likely to be only one child.

Why do couples with lower socioeconomic status have so many unwanted pregnancies? Part of the reason is the fact that some do not begin to use contraception before they have more children than they want. In the grade-school group, 15 percent of the couples had unwanted pregnancies before trying to prevent conception. They account for nearly half of the excess fertility couples in this group. There were hardly any comparable couples in the college group (only 0.2 percent).

Another reason, the study shows, for the high prevalence of unwanted pregnancies among less-educated couples is that after they begin to use contraception they often fail to use it regularly.

These findings indicate that the problem of preventing unwanted pregnancies among the less educated is primarily a problem of their beginning to use contraception earlier and then to use it regularly. It is not simply a matter of making available cheap, effective, and convenient methods of contraception. It is a matter of establishing the habitual use of contraception as a normal and accepted part of married life. This has been stated many times in regard to populations in underdeveloped countries, but it is no less true for the undereducated in our own country.

SUMMARY

A large majority of wives and husbands in the United States agree that the control of fertility is desirable, and most couples who are able to have children either make some attempt to prevent pregnancy or intend to do so. Couples

who have never used contraception and do not expect to begin usually have impairments of the reproductive system.

Most couples want two, three, or four children, and they want them within the first 10 years of marriage. A majority do not use contraception before the first conception. After beginning use, but before having all the children they want, some couples do not use contraception very effectively. Most of those who have had all the children they want, however, are able to prevent unwanted conceptions.

An important minority of 17 percent, however, have had more children than the husband, wife, or both partners wanted. Although "excess fertility" is experienced in all socioeconomic groups, it is most common among couples with low educational attainment and low income. The 1960 study shows that the most important reasons for excess fertility in the lower socioeconomic groups are the failure of some couples to use contraception after they have all the children they want, and the tendency of other couples to use contraception irregularly.

Administration on Aging

A new agency, the Administration on Aging, was established by the Older Americans Act, signed into law on July 14. It becomes the seventh operating agency in the Department of Health, Education, and Welfare.

The Administration supersedes and will expand the work of the Office of Aging. Major responsibilities of the agency lie in areas of informational, consultative, and research activities; administration of grants; and the stimulating of States and communities to use more effectively their resources and services for older people. Grants will be provided to State agencies responsible for programs serving older people to carry out community planning, demonstration projects, and training of personnel; and to various public and private agencies and institutions, for research, development, and professional training.

The President has named William D. Bechill to be the first Commissioner on Aging, pending confirmation by the Senate. The Commissioner will serve as chairman of the 15-member Advisory Committee on Older Americans created by the Act.

Book Note

A GUIDE TO MEDICAL CARE ADMINISTRATION: VOLUME I. CONCEPTS AND PRINCIPLES. Prepared by the Program Area Committee on Medical Care Administration, American Public Health Association. American Public Health Association, Inc., New York, 1965. 106 pp. $2.

Part I of this timely booklet sets forth a generic concept of medical care which includes those who require personal health services, those who provide them, and the organized arrangements for bringing the two groups together. The booklet identifies and describes the people and programs included in each of these groups, the interaction among them, and the factors which account for the differences of attitudes and values that occur. Accessibility, quality, continuity, and efficiency are identified as the essential elements of good medical care and are discussed in sufficient detail to give real meaning to these criteria. The following basic characteristics are ascribed to these elements:

ACCESSIBILITY	QUALITY
Personal Accessibility	Professional Competence
Comprehensive Services	Personal Acceptability
Quantitative Adequacy	Qualitative Adequacy

CONTINUITY	EFFICIENCY
Person-Centered Care	Equitable Financing
Central Source of Care	Adequate Compensation
Coordinated Services	Efficient Administration

Part II describes the several types of medical care programs (programs that organize services, those that organize and finance, and those that finance); the basic process of medical care administration (integration of goals, structure, and functions with the environment of the medical care complex); and the basic administrative procedures by which this process is carried out (program planning, management, and evaluation.)

Since a document of this type is of necessity loaded with technical terms, some of which sound similar but actually have significantly different meanings, a glossary is needed. This need is admirably met in Appendix II. Appendix I contains a list of selected publications of interest to students of medical care, and Appendix III contains a chronology of the public and private actions which constitute the evolution of medical care in the United States.

The document thus provides a perspective for discussion of current problems and issues in medical care--"a disciplined framework which can serve to define the field, its structure, and its goals." A proposed Volume II will offer, within this context, specific guidance to the practicing medical care administrator.

Persons involved in the administration of public assistance will find that the concepts and principles presented have immediate relevance to their tasks in meeting the challenge of the new medical assistance program authorized by Title XIX of the Social Security Act. Administrators will particularly appreciate this discussion as they work on the planning and evaluative phases of their programs.

No consideration is given in this guide to the combinations of training and experience likely to result in an individual's full appreciation of the concepts that are presented and in his skillful performance as an administrator. Discussion of this question would perhaps have added to the usefulness of an already highly useful book.

--Daniel C. Boyle
Division of Medical Services
Bureau of Family Services

Program and Operating Statistics

PUBLIC ASSISTANCE IN JULY 1965

The total number of persons aided under the six public assistance programs[1] declined in July for the fourth consecutive month. More than 8.0 million persons--roughly 76,000 fewer than in June--received assistance. Most of the decline was in aid to families with dependent children; that program's decrease of 51,900 or 1.2 percent included a drop of 31,000 or 8.0 percent in the unemployed-parent segment. The number of persons receiving general assistance decreased by 20,900 or 3.2 percent, and those aided under old-age assistance, aid to the blind, and medical assistance for the aged showed relatively slight declines. The program of aid to the permanently and totally disabled showed an increase of 3,700 or 0.7 percent in the number of recipients.

Expenditures for assistance, including vendor payments for medical care, totaled $454.7 million in July--$5,158,000 less than in June. Payments declined under all programs. The largest decreases were those in medical assistance for the aged ($1.5 million or 3.0 percent) and in old-age assistance ($1.3 million or 0.7 percent).

State activity to adjust individual payments varied in July. Oregon and Utah increased assistance standards in the federally aided programs, and Iowa began meeting need in full for recipients of aid to the permanently and totally disabled. Connecticut liberalized eligibility requirements in medical assistance for the aged.

The rates for nursing home care or hospitalization were raised for some programs in Colorado, Connecticut, New Hampshire, and Rhode Island. South Dakota broadened the scope of medical care in medical assistance for the aged, and Iowa, for the first time, provided recipients of aid to the permanently and totally disabled with the same medical care content as is furnished to recipients of other federally aided programs.

For medical assistance for the aged, Montana and Nevada accepted applications in July; Nevada also made initial payments. There are now 46 States with programs of medical assistance in operation.

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[1]Data for specified types of assistance under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged are classified with data for separate State programs for old-age assistance, aid to the blind, aid to the permanently and totally disabled, or medical assistance for the aged.

Table 1. Number of recipients of public assistance in the United States, by month, July 1964-July 1965 1/

[Except for general assistance, includes cases receiving only vendor payments for medical care]

Year and month	Old-age assistance 2/	Medical assistance for the aged 2/	Aid to the blind 2/	Aid to the permanently and totally disabled 2/	Aid to families with dependent children			General assistance 4/	
					Families	Total recipients 3/	Children	Cases	Recipients
	Number of recipients								
1964									
July	2,177,074	183,866	97,259	508,895	1,009,194	4,191,200	3,142,795	321,000	700,000
August	2,167,588	205,731	97,066	511,595	1,005,821	4,175,979	3,132,370	323,000	713,000
September	2,162,386	206,440	96,853	514,938	1,003,466	4,164,828	3,126,988	321,000	702,000
October	2,160,925	218,790	96,587	519,065	1,005,871	4,174,687	3,138,005	319,000	691,000
November	2,161,452	215,230	96,417	521,787	1,010,020	4,195,145	3,152,501	322,000	702,000
December	2,159,015	224,594	96,438	527,499	1,029,948	4,292,323	3,220,591	346,000	779,000
1965									
January	2,154,586	227,606	96,155	534,602	1,046,971	4,371,936	3,274,859	352,000	806,000
February	2,150,290	228,078	95,834	534,276	1,056,145	4,424,029	3,311,726	352,000	801,000
March	2,151,542	244,534	96,194	540,394	1,073,033	4,491,840	3,360,553	359,000	809,000
April	2,152,244	254,632	95,525	545,285	1,076,061	4,505,880	3,374,923	345,000	759,000
May	2,150,592	257,506	95,504	549,893	1,069,668	4,469,527	3,352,227	327,000	693,000
June	2,149,220	267,030	95,350	555,594	1,062,802	4,429,038	3,325,987	317,000	663,000
July	2,144,951	264,615	95,170	559,287	1,052,529	4,377,147	3,291,558	306,000	643,000
	Percentage change from previous month								
1964									
July	-0.2	-1.7	-0.2	+1.5	-0.5	-0.6	-0.5	-1.5	-1.2
August	-.4	+11.9	-.2	+.5	-.3	-.4	-.3	+.8	+1.9
September	-.2	+.4	-.2	+.7	-.2	-.3	-.2	-.6	-1.5
October	-.1	+6.0	-.3	+.8	+.2	+.2	+.4	-.8	-1.6
November	(5/)	-1.6	-.2	+.5	+.4	+.5	+.5	+1.1	+1.7
December	-.1	+4.4	(5/)	+1.1	+2.0	+2.3	+2.2	+7.4	+10.9
1965									
January	-.2	+1.3	-.3	+1.3	+1.7	+1.9	+1.7	+1.7	+3.5
February	-.2	+.2	-.3	-.1	+.9	+1.2	+1.1	+.2	-.7
March	+.1	+7.2	+.4	+1.1	+1.6	+1.5	+1.5	+1.9	+1.0
April	(5/)	+4.1	-.7	+.9	+.3	+.3	+.4	-3.8	-6.1
May	-.1	+1.1	(6/)	+.8	-.6	-.8	-.7	-5.4	-8.8
June	-.1	+3.7	-.2	+1.0	-.6	-.9	-.8	-2.9	-4.2
July	-.2	-.9	-.2	+.7	-1.0	-1.2	-1.0	-3.5	-3.2

1/ All data subject to revisions. 2/ Represents data for recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Increase of less than 0.05 percent. 6/ Decrease of less than 0.05 percent.

Table 2. Amount of public assistance payments in the United States, by month, July 1964-July 1965 1/

[Except for general assistance, includes vendor payments for medical care]

Year and month	Total 2/	Old-age assistance 3/	Medical assistance for the aged 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Aid to families with dependent children	General assistance 4/
	Amount of assistance						
1964							
July	$423,386,000	$171,666,857	$36,263,042	$8,218,116	$40,135,368	$137,360,488	$21,096,000
August	422,234,000	168,196,378	39,228,163	8,198,173	39,874,356	136,270,529	20,941,000
September	423,655,000	168,527,705	38,263,807	8,179,619	40,478,606	137,613,993	21,263,000
October	434,086,000	170,460,986	43,738,448	8,237,591	41,283,451	139,491,306	21,687,000
November	428,300,000	168,958,898	39,967,657	8,194,102	41,294,048	139,298,640	21,320,000
December	444,770,000	170,316,837	44,141,314	8,271,899	42,514,587	145,182,490	23,743,000
1965							
January	442,181,000	169,149,172	43,848,997	8,275,409	42,486,266	145,748,741	23,191,000
February	446,512,000	170,189,513	42,535,323	8,267,896	43,302,081	148,891,335	23,444,000
March	460,828,000	172,509,810	45,585,652	8,372,511	45,391,949	154,259,544	24,306,000
April	466,251,000	173,958,755	49,842,346	8,315,346	45,629,421	154,713,550	23,252,000
May	457,982,000	171,419,500	49,325,801	8,262,655	45,913,531	152,032,610	21,389,000
June	459,856,000	172,862,075	50,867,075	8,392,761	47,063,386	149,614,741	20,784,000
July	454,698,000	171,604,790	49,320,068	8,283,762	46,671,695	148,816,277	20,185,000
	Percentage change from previous month						
1964							
July	+0.2	+0.3	-1.6	+0.4	+2.0	+0.2	+0.2
August	-.3	-2.0	+8.2	-.2	-.7	-.8	-.7
September	+.3	+.2	-2.5	-.2	+1.5	+1.0	+1.5
October	+2.5	+1.1	+14.3	+.7	+2.0	+1.4	+2.0
November	-1.3	-.9	-8.6	-.5	(5/)	-.1	-1.7
December	+3.8	+.8	+10.4	+.9	+3.0	+4.2	+11.4
1965							
January	-.6	-.7	-.7	(5/)	-.1	+.4	-2.3
February	+1.0	+.6	-3.0	-.1	+1.9	+2.2	+1.1
March	+3.2	+1.4	+7.2	+1.3	+4.8	+3.6	+3.7
April	+1.2	+.8	+9.3	-.7	+.5	+.3	-4.3
May	-1.8	-1.5	-1.0	-.6	+.6	-1.7	-8.0
June	+.4	+.8	+3.1	+1.6	+2.5	-1.5	-2.8
July	-1.1	-.7	-3.0	-1.3	-.8	-.7	-2.9

1/ All data subject to revision. 2/ Total exceeds sum of columns because of inclusion of vendor payments for medical care from general assistance funds and from special medical funds; data for such expenditures partly estimated for some States. 3/ Represents data for payments to recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Increase of less than 0.05 percent.

Table 3. Old-age assistance: Recipients and payments to recipients by State, July 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1965 in--		July 1964 in--	
				Number	Amount	Number	Amount
Total 2/...	2,144,951	$171,604,790	$80.00	-0.2	-0.7	-1.5	(3/)
Ala.....	112,455	7,640,814	67.95	+.2	+1.4	+1.8	+2.6
Alaska 4/.....	1,381	5/ 111,730	80.91	+.7	-17.2	-1.8	-1.6
Ariz.....	13,297	844,879	63.54	-.2	-.1	+1.6	+8.4
Ark.....	59,868	3,818,198	63.78	+.2	+.1	+2.4	+2.7
Calif.....	274,257	29,897,647	109.01	-.3	-.7	+.9	-1.2
Colo. 2/.....	43,864	4,173,918	95.16	-.2	-2.4	-.8	-3.2
Conn.....	6,395	438,008	68.49	-4.5	-34.6	-16.2	-32.1
Del.....	1,430	94,799	66.29	+1.2	-7.0	+10.3	+11.4
Dist. of Col..	2,363	208,402	88.19	+.2	-3.3	-1.8	-1.0
Fla. 4/.....	74,123	4,647,850	62.70	-.1	-3.6	+2.8	-2.6
Ga.....	92,340	5,300,706	57.40	+.1	-1.7	+.5	+2.8
Guam 6/.....	174	13,012	74.78	---	---	---	---
Hawaii 4/.....	1,236	96,832	78.34	+3.3	+12.8	+6.6	-3.2
Idaho.....	4,137	305,179	73.77	-1.1	-.8	-10.4	-11.1
Ill. 4/.....	54,655	5,247,727	96.02	+.1	+1.0	-5.8	+2.7
Ind.....	22,453	1,982,299	88.29	-.5	+1.0	-3.1	+3.1
Iowa.....	26,683	2,569,250	96.29	-.4	+.8	-6.4	-1.4
Kans. 4/.....	21,171	1,955,022	92.34	-1.0	-6.2	-3.7	-1.4
Ky. 4/.....	59,671	3,803,073	63.73	+.4	(3/)	+5.4	+11.5
La.....	131,400	11,163,224	84.96	+.2	+.3	+1.0	+.8
Maine 4/.....	10,911	903,095	83.53	-.4	-.4	-2.8	-3.7
Md. 4/.....	10,095	902,328	89.38	+.6	+21.5	+4.7	+28.8
Mass.....	51,565	4,770,612	92.52	-.5	-1.0	-4.9	-2.3
Mich.....	48,159	4,524,982	93.96	-1.0	-11.0	-3.3	-2.5
Minn.....	31,422	2,843,397	90.49	-.7	+.2	-30.7	-44.9
Miss.....	73,441	2,844,856	38.74	+.1	-5.8	-.6	+.4
Mo.....	101,104	7,046,238	69.69	-.3	-.5	-2.2	+.7
Mont.....	4,438	301,896	68.03	-14.2	-19.4	-17.8	-22.0
Nebr.....	12,385	1,209,147	97.63	-.3	-.3	-1.8	+3.8
Nev.....	2,430	191,560	78.83	-9.0	-17.9	-5.5	-16.0
N. H.....	4,312	448,457	104.00	-1.4	+.7	-3.3	-.7
N. J.....	13,948	1,244,809	89.25	+.1	+.5	+.2	+11.3
N. Mex. 4/....	10,181	820,337	80.58	-.2	+20.2	-5 6	+10.7
N. Y. 4/.....	56,948	5,560,880	97.65	-.2	+3.7	+1.1	+6.6
N. C.....	42,838	2,703,703	63.11	(7/)	+.3	-1.8	-1.9
N. Dak. 4/....	5,115	615,487	120.33	+.7	+24.7	-5.1	+23.4
Ohio.....	80,953	7,401,990	91.44	-.5	-4.3	-3.7	+2.8
Okla. 4/.....	82,338	8,005,714	97.23	(7/)	+1.0	-1.3	+.6
Oreg.....	10,072	755,008	74.96	-.4	+5.4	-8.1	-1.0
Pa.....	45,855	3,695,627	80.59	-.1	+2.4	-2.0	+12.0
P. R. 4/.....	29,696	288,588	9.71	-.6	+.8	-7.1	-4.3
R. I. 4/.....	5,746	563,849	98.13	-.3	+1.6	-3.6	-.1
S. C.....	25,258	1,273,097	50.40	-.5	-22.0	-2.9	+.3
S. Dak.....	6,753	469,573	69.54	-2.9	-32.7	-6.7	-23.7
Tenn.....	44,691	2,732,563	61.14	(7/)	+3.3	-1.2	+16.9
Tex.....	231,168	16,453,381	71.17	+.1	+1.6	+.7	+2.4
Utah.....	4,680	329,644	70.44	-1.1	-.6	-6.5	-5.9
Vt. 4/.....	5,302	471,794	88.98	-1.0	-9.7	-2.7	+.6
V. I. 6/.....	450	17,289	38.42	---	---	---	---
Va.....	13,125	853,120	65.00	-.1	-3.4	-1.9	+3.3
Wash.....	32,234	2,952,031	91.58	-.6	+7.8	-4.0	+4.5
W. Va.....	13,981	758,075	54.22	-.3	-.4	-4.0	+5.8
Wis.....	27,701	3,137,723	113.27	-1.3	+.3	-5.9	+.1
Wyo.....	2,403	201,371	83.80	-.4	-1.2	-4.9	-4.6

1/ All data subject to revision. 2/ Includes 3,810 recipients aged 60-64 in Colorado and payments of $333,453 to these recipients. Such payments were made without Federal participation. 3/ Decrease of less than 0.05 percent. 4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged. 5/ In addition, supplemental payments from general assistance funds were made to recipients. 6/ Data for June; July data not received. 7/ Increase of less than 0.05 percent.

Table 4. Medical assistance for the aged: Recipients and payments for recipients, by State, July 1965 1/

State	Number of recipients 2/	Payments for recipients		Percentage change from June 1965	
		Total amount	Average	Number	Amount
Total.....	264,615	$49,320,068	$186.38	-0.9	-3.0
Alabama.....	312	103,074	330.37	+21.4	+26.8
Arkansas.....	3,184	180,600	56.72	+2.7	-5.0
California.....	32,210	9,555,565	296.66	+1.4	-3.0
Colorado.....	5,002	3/ 961,905	192.30	-11.8	-1.1
Connecticut.....	6,031	3/ 1,214,292	201.34	-18.7	-16.0
Delaware.....	154	17,448	113.30	+18.5	-30.0
Dist. of Col.....	745	261,138	350.52	-9.4	-32.7
Florida 4/.....	917	309,894	337.94	+10.6	+11.3
Guam 5/.....	51	10,824	212.24	---	---
Hawaii 4/.....	305	87,093	285.55	-43.5	-37.9
Idaho.....	2,568	360,155	140.25	+3.8	+5.0
Illinois 4/.....	1,959	828,859	423.10	+33.5	+55.7
Indiana.....	507	89,427	176.38	+24.0	+20.0
Iowa.....	7,326	966,542	131.93	+41.7	+69.9
Kansas 4/.....	2,907	3/ 434,481	149.46	-.9	-6.6
Kentucky 4/.....	12,266	480,707	39.19	-2.2	+36.0
Louisiana.....	613	99,131	161.71	-1.0	+.6
Maine 4/.....	434	111,565	257.06	-27.3	-28.6
Maryland 4/.....	11,437	522,839	45.71	-1.6	-11.9
Massachusetts.....	30,319	3/ 5,298,400	174.76	-.4	-3.8
Michigan.....	6,281	2,315,634	368.67	-2.7	-16.2
Minnesota.....	14,415	3/ 2,699,088	187.24	+.3	-3.6
Nebraska.....	364	3/ 107,433	295.15	+10.0	-5.9
Nevada.....	190	2,020	10.63	(6/)	(6/)
New Hampshire.....	1,299	32,772	25.23	-42.5	-72.1
New Jersey.....	5,538	3/ 1,261,268	227.75	+2.5	+2.6
New York 4/.....	36,912	3/12,415,841	336.36	+.3	-.5
North Carolina....	1,753	40,373	23.03	-16.9	-89.8
North Dakota 4/...	7/ 1,586	3/ 512,140	322.91	+11.2	+54.3
Oklahoma 4/.....	1,223	202,394	165.49	+8.3	+26.6
Oregon.....	3,896	549,506	141.04	-5.5	-10.0
Pennsylvania.....	11,959	3,026,485	253.07	+4.1	+7.6
Puerto Rico 4/....	3,899	124,369	31.90	-3.7	+15.9
Rhode Island 4/...	7,870	532,513	67.66	-9.8	+7.3
South Carolina....	220	34,388	156.31	-93.7	-95.1
South Dakota.....	853	40,120	47.03	+36.3	+36.3
Tennessee.....	7,595	251,073	33.06	-28.3	-27.2
Utah.....	2,315	230,761	99.68	-7.0	-5.4
Vermont 4/.....	130	32,317	248.59	+3.2	+16.8
Virgin Islands 5/.	142	6,888	48.51	---	---
Virginia.....	3,067	194,225	63.33	-13.6	-22.7
Washington.....	10,792	1,606,769	148.89	+3.9	+5.6
West Virginia.....	15,897	419,325	26.38	+43.5	+44.0
Wisconsin.....	7,146	764,592	107.00	+2.5	-17.4
Wyoming.....	26	23,835	(8/)	(8/)	(8/)

1/ All data subject to revision. 2/ Persons for whom vendor payments were made during the report month. 3/ Includes money payments not subject to Federal participation as follows: $26,154 in Colorado, $6 in Connecticut, $11,986 in Kansas, $97,331 in Massachusetts, $35,478 in Minnesota, $99 in Nebraska, $7,723 in New Jersey, $50,118 in New York, and $2,999 in North Dakota. 4/ Represents medical assistance for the aged under a program for aid to the aged, blind, and disabled and medical assistance for the aged. 5/ Data for June; July data not received. 6/ Program initiated in July 1965. 7/ Includes an unknown number of cases receiving only money payments. 8/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.

Table 5. Aid to the blind: Recipients and payments to recipients, by State, July 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage from--			
		Total amount	Average	June 1965 in--		July 1964 in--	
				Number	Amount	Number	Amount
Total 2/..	95,170	$8,283,762	$87.04	-0.2	-1.3	-2.1	+0.8
Ala.....	1,862	128,235	68.87	+.9	+1.1	+5.0	+9.8
Alaska 3/.....	111	9,152	82.45	0	-1.7	0	+9.1
Ariz.....	811	58,197	71.76	-.9	-.7	-2.4	-3.4
Ark.....	1,941	138,110	71.15	-.1	+.7	-.7	-2.0
Calif. 2/.....	12,405	1,654,157	133.35	+.1	-8.1	-1.1	-.9
Colo.....	248	22,011	88.75	-.4	+1.1	-2.4	-2.4
Conn.....	302	29,202	96.70	-2.3	-30.0	-3.5	-14.5
Del.....	320	26,168	81.78	+1.9	+.9	+4.9	+8.8
Dist. of Col....	204	15,809	77.50	0	-1.2	-.5	+6.4
Fla. 3/.....	2,588	170,397	65.84	-.1	-2.6	-.3	-2.7
Ga.....	3,198	190,112	59.45	+.3	-1.8	+.7	+.5
Guam 4/.....	6	179	(5/)	---	---	---	---
Hawaii 3/.....	65	7,337	112.88	(5/)	(5/)	(5/)	(5/)
Idaho.....	132	9,707	73.54	0	+2.2	-.8	-1.4
Ill. 3/.....	2,379	229,662	96.54	-.5	-.6	-6.4	+.1
Ind.....	1,769	174,443	98.61	+.6	+11.9	-1.2	+8.3
Iowa.....	1,131	115,034	101.71	0	-.9	-4.7	-3.9
Kans. 3/.....	497	48,204	96.99	-1.2	-5.2	-2.0	+3.3
Ky. 3/.....	2,497	182,516	73.09	-.3	-2.3	+2.8	+6.9
La.....	2,742	223,794	81.62	-.5	-.1	-2.8	-2.4
Maine 3/.....	294	25,171	85.62	-2.3	-3.3	-12.0	-10.9
Md. 3/.....	399	33,961	85.12	+1.8	+7.0	+.8	+7.1
Mass.....	2,232	320,505	143.60	-.2	+4.4	-2.1	+6.6
Mich.....	1,658	143,430	86.51	-.5	-8.7	-1.0	-3.5
Minn.....	1,058	118,898	112.38	+.2	+.3	-1.4	-5.1
Miss.....	2,581	116,657	45.20	(6/)	-1.5	-9.2	-8.6
Mo. 2/.....	4,333	324,975	75.00	-.4	-.4	-5.2	-5.2
Mont.....	235	18,314	77.93	-2.3	-13.7	-6.0	-12.6
Neb.....	622	64,079	103.02	0	-2.6	-3.6	-2.9
Nev.....	165	16,500	100.00	+3.8	-12.7	+3.1	-13.0
N. H.....	258	28,129	109.03	-.8	(7/)	+.8	+2.5
N. J.....	919	81,498	88.68	-.3	-.3	-3.6	-.9
N. Mex. 3/.....	343	33,211	96.83	-1.7	+14.8	+1.5	+16.4
N. Y. 3/.....	3,162	397,716	125.78	-.7	+7.0	-1.0	+10.8
N. C.....	4,935	351,445	71.21	+.2	+1.6	-3.0	+4.3
N. Dak. 3/.....	80	7,516	93.95	(5/)	(5/)	(5/)	(5/)
Ohio.....	3,241	278,099	85.81	-.6	+2.8	-3.4	-2.1
Okla. 3/.....	1,622	200,081	123.35	+.2	+1.1	-3.7	-2.0
Oreg.....	477	48,201	101.05	+1.7	+14.7	+13.6	+37.6
Pa. 2/.....	17,482	1,351,252	77.29	-.3	+1.7	-2.2	+.7
P. R. 3/.....	1,363	12,047	8.84	-.8	+.5	-8.3	-3.2
R. I. 3/.....	107	10,411	97.30	+.9	+4.3	(5/)	(5/)
S. C.....	1,867	113,044	60.55	+.1	-18.4	+4.5	+7.4
S. Dak.....	112	7,917	70.69	0	+3.3	-7.4	-5.4
Tenn.....	2,053	121,389	59.13	-.3	+5.5	-5.8	+6.4
Tex.....	4,647	324,155	69.76	-.5	-.4	-3.1	-2.5
Utah.....	167	13,444	80.50	0	+6.7	-3.5	-5.2
Vt. 3/.....	120	8,646	72.05	0	-8.5	+5.3	+9.1
V. I. 4/.....	10	360	(5/)	---	---	---	---
Va.....	1,131	80,399	71.09	-.8	-2.7	-.4	+4.4
Wash.....	679	67,665	99.65	+1.3	+8.6	+1.5	+7.1
W. Va.....	773	44,058	57.00	-.9	-2.0	-4.9	+11.8
Wis.....	781	83,060	106.35	-1.5	-2.6	-3.2	-1.7
Wyo.....	56	5,103	91.12	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision. 2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $11,948 to 79 recipients; Missouri, $53,556 to 703 recipients; and Pennsylvania, $972,110 to 12,804 recipients. 3/ Represents aid to the blind under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Data for June; July data not received. 5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 6/ Increase of less than 0.05 percent. 7/ Decrease of less than 0.05 percent.

Table 6. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, July 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1965 in--		July 1964 in--	
				Number	Amount	Number	Amount
Total.....	559,287	$46,671,695	$83.45	+0.7	-0.8	+9.9	+16.3
Ala.....	14,958	702,152	46.94	(2/)	+1.3	+2.6	+4.1
Alaska 3/.....	220	23,898	108.63	+1.4	-34.1	+36.6	+29.3
Ariz.....	3,769	253,821	67.34	+.5	+.5	+25.6	+25.8
Ark.....	9,683	592,718	61.21	+.7	-.4	+4.7	+8.9
Calif.....	74,711	8,519,045	114.03	+2.2	-1.0	+47.7	+46.0
Colo.....	6,147	478,202	77.79	(2/)	-2.2	-39.1	-4.5
Conn.....	8,441	577,742	68.44	-.4	-24.7	+16.0	+1.4
Del.....	451	34,421	76.32	+1.6	+1.3	+6.9	+11.1
Dist. of Col....	3,371	282,822	83.90	+1.4	+2.4	+7.2	+14.5
Fla. 3/.....	17,746	1,166,139	65.71	(4/)	-3.7	+9.0	+.1
Ga.....	27,053	1,647,119	60.88	+.1	-.9	+2.7	+5.6
Guam 5/.....	45	1,399	(6/)	---	---	---	---
Hawaii 3/.....	1,151	128,447	111.60	-5.3	-10.0	+19.0	-21.5
Idaho.....	3,089	179,738	58.19	+.2	+1.6	+7.8	+9.7
Ill. 3/.....	30,193	3,065,538	101.53	+1.1	+1.2	+6.9	+16.9
Ind.....	1,645	195,862	119.07	+2.2	-10.3	+41.2	+47.2
Iowa.....	1,293	111,223	86.02	+.7	+3.9	+12.7	+17.3
Kans. 3/.....	5,133	564,189	109.91	+.6	-3.6	+9.5	+9.7
Ky. 3/.....	11,624	905,352	77.89	+1.4	+1.0	+16.7	+24.5
La.....	19,737	1,161,576	58.85	+.4	+.6	+4.4	+5.8
Maine 3/.....	2,266	204,885	90.42	+.1	+.2	+1.4	+4.6
Md. 3/.....	8,038	733,161	91.21	+.9	+6.3	+7.7	+26.0
Mass.....	13,253	1,920,441	144.91	(4/)	-4.4	+10.5	+13.0
Mich.....	12,471	1,236,374	99.14	+4.1	-10.3	+60.4	+44.1
Minn.....	3,950	293,099	74.20	+.8	+21.9	+12.7	+37.0
Miss.....	19,174	840,964	43.86	+.5	+.4	+8.7	+9.6
Mo.....	15,439	1,135,013	73.52	+.7	+1.7	+5.0	+9.8
Mont.....	1,532	106,686	69.64	+11.9	-1.5	+19.1	+5.9
Nebr.....	2,737	273,777	100.03	+.4	+2.6	+10.6	+16.8
N. H.....	624	72,444	116.10	+.2	-1.9	+8.5	+9.4
N. J.....	8,867	894,950	100.93	+.7	+.2	+4.8	+9.7
N. Mex. 3/.....	3,909	363,888	93.09	+.4	+18.1	+6.1	+23.2
N. Y. 3/.....	36,326	4,934,727	135.85	+.2	+1.1	+3.5	+10.0
N. C.....	22,609	1,552,143	68.65	-1.1	-12.0	+2.9	-2.0
N. Dak. 3/.....	1,775	291,852	164.42	+2.5	+26.4	+18.9	+73.8
Ohio.....	19,897	1,623,250	81.58	+.8	+4.6	+4.6	+6.6
Okla. 3/.....	14,794	1,673,551	113.12	+.7	+1.5	+12.0	+14.9
Oreg.....	8,265	605,213	73.23	+.7	+8.0	+6.1	+17.4
Pa.....	21,029	1,667,452	79.29	+.4	+2.6	+6.2	+15.1
P. R. 3/.....	20,569	180,693	8.78	-.4	-4.5	-3.6	-1.8
R. I. 3/.....	2,912	283,654	97.41	+.4	+1.8	+5.9	+9.0
S. C.....	9,075	462,891	51.01	+.1	-19.4	+4.7	+5.8
S. Dak.....	1,116	65,021	58.26	+.4	-16.7	+2.3	-15.2
Tenn.....	13,633	773,489	56.74	+.5	+3.5	+8.2	+20.6
Tex.....	10,014	572,456	57.17	+.3	+.4	+6.6	+6.6
Utah.....	4,953	339,934	68.63	-.2	+2.1	+4.3	+3.2
Vt. 3/.....	1,286	104,610	81.35	+.3	-6.1	+17.4	+19.3
V. I. 5/.....	56	2,161	38.59	---	---	---	---
Va.....	6,905	475,486	68.86	-.1	-3.1	+2.7	+6.7
Wash.....	18,448	1,267,554	68.71	+.4	+4.7	-.4	+7.8
W. Va.....	5,791	308,104	53.20	-.4	-.5	-4.4	-1.2
Wis.....	6,409	758,410	118.34	+.3	-3.5	+7.4	+10.2
Wyo.....	705	61,959	87.89	0	+5.5	+14.4	+28.5

1/ All data subject to revision. 2/ Increase of less than 0.05 percent. 3/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Decrease of less than 0.05 percent. 5/ Data for June; July data not received.

Table 7. Aid to families with dependent children: Recipients and payments to recipients, by State, July 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		June 1965 in--		July 1964 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total	1,052,529	4,377,147	3,291,558	$148,816,277	$141.39	$34.00	-1.2	-0.7	+4.4	+8.3
Ala. 3/	17,914	73,245	57,958	864,987	48.29	11.81	-1.0	-.9	-19.2	-18.3
Alaska 3/	1,269	4,681	3,582	165,848	130.69	35.43	-4.2	-2.6	-.1	+1.5
Ariz. 3/	9,329	40,197	30,330	1,153,327	123.63	28.69	-1.3	-1.4	-1.0	-2.2
Ark.	7,344	30,893	23,306	511,146	69.60	16.55	-1.6	-3.6	+6.5	+5.0
Calif. 3/ 4/	136,227	553,773	410,739	24,337,303	178.65	43.95	-2.2	-.2	+15.0	+17.1
Colo.	11,325	44,053	34,156	1,700,321	150.14	38.60	(5/)	+2.0	+8.2	+16.4
Conn 4/	14,091	56,473	41,461	2,472,274	175.45	43.78	-5.2	-14.2	-3.5	-12.2
Del. 4/	2,582	11,382	8,690	325,404	126.03	28.59	-2.4	-2.1	+7.2	+10.0
Dist. of Col.	4,502	21,505	17,339	702,830	156.12	32.68	+1.2	+1.3	+12.0	+11.9
Fla.	27,846	107,792	86,309	1,688,634	60.64	15.67	-.1	-.1	+5.1	+2.9
Ga.	18,508	74,416	57,119	1,649,970	89.15	22.17	-.5	-.3	+16.2	+16.1
Guam 6/	135	764	652	11,633	86.17	15.23	---	---	---	---
Hawaii 4/	3,127	13,535	10,044	558,410	178.58	41.26	-.7	+16.2	+1.4	+2.5
Idaho	2,590	9,885	7,216	388,157	149.87	39.27	-2.0	-.7	+3.0	+6.6
Ill. 3/ 4/	55,537	260,747	201,853	11,657,285	209.90	44.71	-.4	-.9	+.3	+2.9
Ind. 3/	11,955	48,969	36,685	1,439,122	120.38	29.39	-.1	-1.0	+1.3	+2.7
Iowa	11,296	45,401	33,037	1,744,153	154.40	38.42	-.6	-1.8	+8.2	+9.5
Kans. 3/ 4/	8,882	37,636	28,938	1,419,646	159.83	37.72	-1.7	-4.4	+11.1	+11.0
Ky. 3/	21,451	83,879	60,316	2,105,002	98.13	25.10	-.1	-1.9	+7.8	+10.5
La. 3/	23,958	104,888	79,715	2,443,315	101.98	23.29	-.5	-.4	+3.7	+5.8
Maine	5,059	18,520	13,616	533,990	105.55	28.83	-2.5	-2.5	-4.7	-4.9
Md. 3/ 4/	20,279	85,574	66,052	3,043,253	150.07	35.56	+.1	+5.4	+19.9	+30.7
Mass. 4/	26,279	99,361	74,587	4,702,171	178.93	47.32	+.8	-.1	+9.8	+10.5
Mich. 3/ 4/	39,064	159,112	118,207	5,649,625	144.62	35.51	-2.7	-5.0	+.2	+.4
Minn. 3/	14,532	53,115	41,390	2,669,582	183.70	50.26	-.1	-4.0	+9.8	+8.5
Miss.	20,701	83,391	66,900	763,459	36.88	9.16	-.2	+.1	+.4	-6.8
Mo. 3/	26,264	108,561	82,801	2,639,626	100.50	24.31	+.1	+.1	+2.2	+3.2
Mont.	1,915	7,737	6,011	280,852	146.66	36.30	+2.9	+2.4	+8.3	+11.7
Nebr.	4,244	17,334	13,297	542,913	127.92	31.32	+1.1	-.3	+15.0	+17.3
Nev.	1,281	5,260	4,153	166,512	129.99	31.66	-1.4	-.6	+10.3	+10.6
N. H.	1,123	4,583	3,414	203,083	180.84	44.31	-2.9	-1.6	+9.7	+12.2
N. J.	27,825	110,347	83,710	5,555,445	199.66	50.35	+.6	+.7	+9.7	+13.6
N. Mex. 3/	7,192	29,901	22,877	968,572	134.67	32.39	+.8	+8.7	-5.9	-11.1
N. Y. 4/	126,183	539,279	396,622	25,639,876	203.20	47.54	-.2	(5/)	+10.2	+15.7
N. C. 3/	25,924	107,323	80,282	2,641,558	101.90	24.61	-5.5	-8.6	-.5	+.9
N. Dak.	2,109	8,403	6,402	412,181	195.44	49.05	+.3	+7.9	+15.0	+33.3
Ohio 4/	45,191	191,709	142,778	6,223,403	137.71	32.46	-2.0	+1.8	+13.2	+11.9
Okla. 3/ 4/	18,670	74,266	55,301	2,588,905	138.67	34.86	-.4	+4.6	+.9	+1.5
Oreg. 3/ 4/	8,045	31,227	23,145	1,219,738	151.61	39.06	-4.1	-3.5	+10.6	+14.3
Pa. 4/	65,292	286,477	207,302	9,043,182	138.50	31.57	-1.0	-.2	-8.5	-3.7
P. R.	48,259	195,549	156,305	800,030	16.58	4.09	-.7	-1.7	-5.0	-18.6
R. I. 4/	5,918	23,577	17,454	1,000,106	168.99	42.42	(5/)	+1.8	+.7	+2.9
S. C.	7,045	28,019	22,583	431,516	61.25	15.40	-3.8	-15.8	-7.3	-7.1
S. Dak.	3,099	11,618	8,738	377,404	121.78	32.48	+.9	+1.9	+12.1	+14.4
Tenn. 3/	19,360	77,813	59,377	1,891,260	97.69	24.31	-.1	+8.2	+2.4	+24.7
Tex.	20,250	92,151	69,660	1,725,852	85.23	18.73	-2.0	-1.9	+7.2	+11.5
Utah 3/ 4/	5,424	22,790	16,189	754,945	139.19	33.13	-2.2	+.7	+12.9	+12.8
Vt.	1,467	5,556	4,072	164,986	112.46	29.70	-1.7	-1.7	+2.6	+2.4
V. I. 6/	295	1,039	887	20,854	70.69	20.07	---	---	---	---
Va. 3/	10,736	45,627	35,208	1,143,798	106.54	25.07	-.8	-1.6	+2.6	+7.3
Wash. 3/ 4/	17,623	69,642	49,829	2,526,269	143.35	36.28	-6.2	-3.2	+6.8	+5.3
W. Va. 3/ 4/	23,762	109,914	76,455	2,932,028	123.39	26.68	-2.4	-2.6	-5.6	-5.6
Wis. 3/	11,269	44,482	33,592	2,075,926	184.22	46.67	+.3	-.6	-.1	+2.7
Wyo.	982	3,776	2,917	144,610	147.26	38.30	-.9	-2.2	+14.8	+17.2

1/ All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Includes data on foster-family care; see table 10. 4/ Includes data on unemployed-parent segment; see table 8. 5/ Increase of less than 0.05 percent. 6/ Data for June; July data not received.

Table 8. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, July 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
		Total 2/	Children	Total	Average per--		June 1965 in--		July 1964 in--	
					Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	61,583	357,258	241,364	$11,327,607	$183.94	$31.71	-8.0	-5.7	-3.7	+1.0
California.....	13,412	77,092	52,642	2,677,955	199.67	34.74	-10.4	-2.4	+35.3	+46.7
Connecticut.....	1,423	8,261	5,500	234,898	165.07	28.43	-16.3	-10.6	-33.9	-33.3
Delaware.....	206	1,168	787	35,490	172.28	30.39	-10.4	+1.4	-29.7	-21.4
Hawaii.....	257	1,658	1,145	59,510	231.56	35.89	+3.0	+27.7	-5.7	+2.9
Illinois.....	5,227	33,909	23,696	1,373,961	262.86	40.52	-6.7	-8.2	-21.7	-20.7
Kansas.....	358	2,248	1,546	76,599	213.96	34.07	-7.0	-10.5	+9.3	+25.2
Maryland.....	324	1,874	1,243	56,031	172.94	29.90	-8.7	-5.3	-17.0	-14.6
Massachusetts....	666	3,673	2,452	159,530	239.53	43.43	+.7	+.2	-4.8	+22.5
Michigan.....	2,508	16,063	11,134	555,899	221.65	34.61	-18.2	-10.7	-32.5	-21.8
New York.....	14,119	81,566	55,377	2,690,046	190.53	32.98	-5.0	-6.2	-.3	+2.7
Ohio.....	4,517	26,065	17,596	777,855	172.21	29.84	-7.9	-1.6	+122.8	+127.4
Oklahoma.....	21	137	96	3,619	(3/)	(3/)	-.7	+1.4	(3/)	(3/)
Oregon.....	766	4,171	3,015	133,292	174.01	31.96	-18.3	-24.8	+39.2	+20.2
Pennsylvania.....	5,429	30,845	20,430	674,831	124.30	21.88	-1.9	-3.0	-37.9	-40.3
Rhode Island.....	355	2,126	1,433	71,149	200.42	33.47	-3.0	-3.3	-31.6	-35.3
Utah.....	971	5,276	3,523	108,529	111.77	20.57	-3.0	-.6	+19.7	+28.9
Washington.....	1,931	10,600	6,813	268,720	139.16	25.35	-24.4	-22.2	-9.5	-4.0
West Virginia....	9,093	50,526	32,936	1,369,693	150.63	27.11	-4.3	-4.5	-11.7	-11.7

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Average payment not computed on base of fewer than 50 families; percentage change on fewer than 100 recipients.

Table 9. Aid to families with dependent children: Recipients and money payments to recipients under community work and training programs, by State, July 1965 1/

State	Number of families with an adult on work and training programs	Number of recipients				Money payments to recipients			
		Total 2/	Adults		Children	Total	For work performed on work and training programs	Average per family	
			On work and training programs	Other				Total	For work performed on work and training programs
Total.....	20,663	114,421	20,666	18,159	75,596	$3,863,189	$2,756,317	$186.96	$133.39
California.....	5,069	25,317	5,069	3,953	16,295	1,334,411	477,726	263.25	94.24
Illinois.....	1,846	11,564	1,849	1,610	8,105	392,816	318,501	212.79	172.54
Kansas.....	95	532	95	84	353	21,892	7,240	230.44	76.21
Maryland.....	104	634	104	98	432	18,932	12,682	182.04	121.94
Michigan.....	428	2,698	428	426	1,844	101,395	34,336	236.90	80.22
Ohio.....	3,039	17,477	3,039	2,526	11,912	643,120	591,818	211.62	194.74
Oregon.....	86	447	86	62	299	17,829	8,755	207.31	101.80
Pennsylvania.....	622	3,704	622	622	2,460	111,592	89,893	179.41	144.52
Washington.....	281	1,522	281	281	960	42,200	36,364	150.18	129.41
West Virginia.....	9,093	50,526	9,093	8,497	32,936	1,179,002	1,179,002	129.66	129.66

1/ Represents data for community work and training programs under plans for such programs submitted under Section 409 of Social Security Act. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.

Table 10. Aid to families with dependent children receiving foster care: Recipients and payments for foster care, by State, July 1965 1/

State	Number of				Payments for foster care			
	Children receiving foster care			Families from which children were removed	Total amount	Average per child	In foster homes	In institutions
	Total	In foster homes	In institutions					
Total...	6,724	2/ 5,267	2/ 294	2,797	$497,816	$74.04	2/ $344,453	2/ $46,843
Ala.....	5	5	0	3	200	(3/)	200	0
Alaska.....	73	73	0	21	7,499	102.73	7,499	0
Ariz.....	207	207	0	75	9,988	48.25	9,988	0
Calif.....	1,373	1,236	137	655	131,341	95.66	102,020	29,321
Ill.....	1,163	(2/)	(2/)	477	106,520	91.59	(2/)	(2/)
Ind.....	149	149	0	49	5,786	38.83	5,786	0
Kans.....	102	93	9	41	9,120	89.41	8,117	1,003
Ky.....	27	27	0	12	1,862	(3/)	1,862	0
La.....	585	549	36	249	39,887	68.18	35,723	4,164
Md.....	724	686	38	248	53,992	74.57	50,422	3,570
Mich.....	65	58	7	25	4,363	67.12	3,538	825
Minn.....	184	155	29	89	16,288	88.52	10,687	5,601
Mo.....	89	89	0	23	2,848	32.00	2,848	0
N. Mex.....	65	65	0	15	3,741	57.55	3,741	0
N. C.....	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)	(4/)
Okla.....	323	323	0	140	14,516	44.94	14,516	0
Oreg.....	97	97	0	43	6,309	65.04	6,309	0
Tenn.....	259	226	33	85	16,325	63.03	14,400	1,925
Utah.....	305	305	0	147	15,254	50.01	15,254	0
Va.....	59	59	0	22	2,606	44.17	2,606	0
Wash.....	656	656	0	292	36,027	54.92	36,027	0
W. Va.....	69	64	5	29	4,069	58.97	3,635	434
Wis.....	145	145	0	57	9,275	63.97	9,275	0

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Excludes Illinois; breakdown not available. 3/ Average payment not computed on base of fewer than 50 children. 4/ Program in operation but no payments made in July 1965.

Table 11. General assistance: Recipients and payments to recipients, by State, July 1965 1/

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		June 1965 in--		July 1964 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/....	306,000	643,000	$20,185,000	$65.94	$31.41	-3.2	-2.9	-8.1	-4.3
Ala.....	70	70	889	12.70	12.70	(3/)	(3/)	(3/)	(3/)
Alaska.....	118	341	6,976	59.12	20.46	-48.3	-35.5	-31.8	-17.1
Ariz.....	1,847	4,220	104,538	56.60	24.77	-16.0	-10.2	+3.4	+1.1
Ark.....	344	1,193	5,324	15.48	4.46	+21.0	+25.1	-12.5	-12.7
Calif.....	18,957	31,804	1,118,662	59.01	35.17	+.8	-8.6	-27.0	-21.2
Colo.....	1,052	3,668	53,260	50.63	14.52	-27.0	-15.7	-17.8	-2.0
Conn.....	4/ 4,678	4/ 12,431	4/ 329,884	70.52	26.54	-.7	-.5	+24.6	+20.6
Del.....	1,494	2,632	77,000	51.54	29.26	-1.6	-6.4	-2.6	-.2
Dist. of Col.....	774	827	60,361	77.99	72.99	-3.8	-.6	+25.1	+29.2
Fla. 5/.....	8,200	(6/)	249,000	---	---	---	---	---	---
Ga.....	2,229	5,232	70,041	31.42	13.39	+7.8	-2.6	+.6	+1.4
Guam 7/.....	28	28	1,207	(3/)	(3/)	---	---	---	---
Hawaii.....	956	1,234	83,027	86.85	67.28	+1.6	+20.5	-4.6	+16.1
Ill.....	25,359	53,625	2,002,139	78.95	37.34	+4.4	+3.2	-8.8	-12.0
Iowa 5/.....	3,500	7,600	127,000	---	---	---	---	---	---
Kans.....	2,802	6,450	187,532	66.93	29.07	+1.8	-1.0	+5.7	+5.6
Ky.....	1,274	4,065	43,650	34.26	10.74	+38.4	+14.5	+7.7	-8.6
La.....	8,057	8,874	420,224	52.16	47.35	-1.0	-.8	-.6	-.9
Maine.....	2,502	8,050	109,446	43.74	13.60	-.3	+.5	+10.0	+7.2
Md.....	7,586	8,593	579,312	76.37	67.42	-6.8	+1.6	+19.0	+25.1
Mass.....	7,233	14,892	535,605	74.05	35.97	-.7	-3.6	-3.9	-3.8
Mich.....	18,482	51,296	1,385,180	74.95	27.00	-7.7	-5.1	-24.5	-21.3
Minn.....	7,888	21,411	617,159	78.24	28.82	-14.4	-11.0	-13.0	-14.7
Miss.....	1,264	1,584	20,398	16.14	12.88	+1.7	+9.2	-5.7	+9.5
Mo.....	9,781	12,349	642,838	65.72	52.06	-3.1	-2.1	+1.9	+2.3
Mont.....	915	2,721	45,138	49.33	16.59	-11.8	-17.1	-33.7	-23.9
Nev.....	343	602	18,626	54.30	30.94	+8.3	-14.0	-12.9	-8.6
N. H.....	763	2,692	45,470	59.59	16.89	-.9	-11.8	-9.7	-17.3
N. J. 8/.....	9,180	28,851	1,070,373	116.60	37.10	-3.7	-9.0	-2.1	-.1
N. Mex.....	268	533	11,829	44.14	22.19	+1.9	-2.5	-34.2	-34.1
N. Y. 9/.....	51,007	109,310	4,315,204	84.60	39.48	-.2	-1.6	+14.9	+18.5
N. C.....	1,400	4,060	37,079	26.48	9.13	+1.2	-5.9	+3.8	+23.6
N. Dak.....	276	1,032	15,085	54.66	14.62	-13.3	-15.5	-16.5	-30.4
Ohio.....	24,679	74,225	1,621,986	65.72	21.85	-.3	-1.3	-19.4	-19.9
Okla.....	7,309	(6/)	85,757	11.73	---	---	-30.6	---	+8.8
Oreg.....	4,406	(6/)	236,968	53.78	---	---	-8.5	---	+26.9
Pa.....	34,004	41,104	2,195,471	64.57	53.41	-1.6	-.8	-8.1	-4.2
P. R.....	566	566	5,205	9.20	9.20	-77.4	-78.2	-54.1	-56.7
R. I.....	3,211	8,097	218,359	68.00	26.97	+23.7	+28.5	+9.1	+3.8
S. C.....	1,133	1,333	39,066	34.48	29.31	-12.1	-2.1	-14.1	-9.6
S. Dak.....	350	1,309	12,253	35.01	9.36	+3.2	+1.6	+5.5	+15.0
Tenn.....	1,808	2,804	47,730	26.40	17.02	-14.0	-9.7	-34.2	+34.4
Tex. 10/.....	8,600	(6/)	240,000	---	---	---	---	---	---
Utah.....	787	1,074	42,255	53.69	39.34	-77.6	-65.6	-75.9	-64.6
Vt. 10/.....	1,100	(6/)	25,000	---	---	---	---	---	---
V. I. 7/.....	205	216	7,602	37.08	35.19	---	---	---	---
Va.....	2,587	6,133	131,975	51.01	21.52	-7.1	-.5	+4.3	+9.4
Wash.....	7,891	12,297	557,944	70.71	45.37	-.9	-2.0	-7.6	+8.4
W. Va.....	1,781	2,815	64,578	36.26	22.94	+4.5	+1.8	+17.1	+18.3
Wis.....	5,782	17,221	499,390	86.37	29.00	-7.4	-8.3	-24.1	-28.8
Wyo.....	289	1,037	20,245	70.05	19.52	-10.2	-17.4	-.6	-5.3

1/ All data subject to revision. 2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count also includes an estimate for States not reporting such data. Excludes Idaho, Indiana, and Nebraska; data not available. 3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 4/ About 12 percent of this total is estimated. 5/ Partly estimated. 6/ Data not available. 7/ Data for June; July data not received. 8/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial, and total payments for such services. 9/ Includes and unknown number of cases and persons receiving only medical care. 10/ Estimated on basis of reports from sample of local jurisdictions.

Table 12. Amount of vendor payments for medical care for recipients of public assistance, by program and State, July 1965 1/

State	Old-age assistance	Medical assistance for the aged	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 1/
Total	$37,837,794	$49,320,068	$1,053,332	$11,599,081	$13,841,887	$9,816,000
Ala.	1,218,660	103,074	4,071	74,221	749	5
Alaska 2/	13,981	(3/)	---	8,217	20	56,018
Ariz.	73,649	(3/)	---	---	---	---
Ark.	786,445	180,600	21,290	218,766	45,826	26,873
Calif.	3,303,362	9,555,565	186,543	1,189,391	1,585,760	---
Colo.	667,297	4/ 961,905	4,588	92,877	142,510	55,114
Conn.	35,278	4/ 1,214,292	8,280	207,518	261,387	---
Del.	20,417	17,448	---	---	---	---
D. C.	58,342	261,138	509	39,408	1,008	363
Fla. 2/	987,544	309,894	14,722	166,969	54,544	---
Ga.	950,208	(3/)	11,022	172,319	333	---
Guam 5/	---	10,824	---	---	75	---
Hawaii 2/	7,133	87,093	2,053	45,814	21,302	6,728
Idaho	44,620	360,155	85	24,506	---	---
Ill. 2/	2,723,496	828,859	80,172	1,035,980	1,766,043	810,118
Ind.	985,540	89,427	65,364	114,980	278,490	---
Iowa	1,039,778	966,542	10,993	---	174,212	6/ 286,000
Kans. 2/	460,088	4/ 434,481	8,670	101,556	195,504	125,564
Ky. 2/	866,947	480,707	25,318	186,349	281,844	---
La.	2,377,053	99,131	7,687	116,347	47,962	4,757
Maine 2/	335,110	111,565	3,675	46,453	25,295	98,315
Md. 2/	451,834	522,839	8,382	212,467	---	5,169
Mass.	1,164,088	4/ 5,298,400	29,339	1,029,001	585,578	230,856
Mich.	588,665	2,315,634	9,808	167,833	138,310	503,867
Minn.	1,103,324	4/ 2,699,088	39,074	62,869	420,881	323,001
Miss.	85,165	(3/)	910	---	---	---
Mo.	1,175,126	(3/)	---	88,186	69,799	28,735
Mont.	1,030	(7/)	60	---	---	389,530
Nebr.	711,019	4/ 107,433	30,100	147,134	62,666	---
Nev.	19,366	2,020	1,340	(3/)	10,290	160,328
N. H.	101,327	32,772	5,012	22,741	37,513	---
N. J.	338,607	4/ 1,261,268	11,205	263,148	335,523	255,989
N. Mex. 2/	227,367	(3/)	7,875	90,006	89,721	5,650
N. Y. 2/	1,370,771	4/ 12,415,841	129,595	2,279,592	3,183,298	322,430
N. C.	406,961	40,373	25,358	199,346	164,846	82,616
N. Dak. 2/	278,791	4/ 512,140	2,010	178,455	100,864	12,379
Ohio	1,930,780	(3/)	52,056	336,678	729,875	1,470,778
Okla. 2/	1,715,360	202,394	33,635	307,001	186,150	---
Oreg.	154,375	549,506	7,897	208,846	125,717	75,485
Pa.	779,692	3,026,485	93,321	461,417	1,180,122	1,415,204
P. R. 2/	34,978	124,369	402	3,622	---	---
R. I. 2/	102,221	532,513	1,953	58,065	144,056	78,741
S. C.	261,735	34,388	11,283	52,433	4,280	6,530
S. Dak.	114,801	40,120	---	---	---	129,059
Tenn.	580,983	251,073	2,566	14,996	33,942	---
Tex.	3,147,261	(3/)	---	---	---	---
Utah	53,696	230,761	3,785	133,103	76,410	2,602
Vt. 2/	219,642	32,317	1,402	26,897	---	---
V. I. 5/	353	6,888	3	56	148	200
Va.	246,443	194,225	11,761	82,767	42,984	23,898
Wash.	994,713	1,606,769	22,214	722,276	485,037	216,402
W. Va.	206,457	419,325	11,472	74,331	400,524	16,599
Wis.	2,280,094	764,592	43,508	520,624	341,699	176,712
Wyo.	35,821	23,835	964	13,520	8,790	37,617

1/ Data incomplete. Some States do not report these data and for some the data represent only partial reporting. The total includes an estimated amount for these States. 2/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ No program in operation. 4/ Includes money payments not subject to Federal participation as follows: $26,154 in Colorado, $6 in Connecticut, $12,481 in Kansas, $97,331 in Massachusetts, $35,478 in Minnesota, $99 in Nebraska, $7,723 in New Jersey, $50,118 in New York, and $2,999 in North Dakota. 5/ Data for June; July data not received. 6/ Partly estimated. 7/ Program in operation, but no payments made in July.

Table 13. Average payment per recipient for all assistance, for money payments, and for vendor payments for medical care, by program and State, July 1965 1/

State	Old-age assistance			Medical assistance for the aged	Aid to the blind			Aid to the permanently and totally disabled			Aid to families with dependent children (per recipient)		
	All assistance	Money payments to recipients	Vendor payments for medical care		All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care
Total.....	$80.00	$62.36	$17.64	$186.38	$87.04	$75.97	$11.07	$83.45	$62.71	$20.74	$34.00	$30.84	$3.16
Ala.....	67.95	57.09	10.84	330.37	68.87	66.68	2.19	46.94	41.98	4.96	11.81	11.80	.01
Alaska 2/.....	80.91	70.78	10.12	(3/)	82.45	82.45	---	108.63	71.28	37.35	35.43	35.43	(4/)
Ariz.....	63.54	58.00	5.54	(3/)	71.76	71.76	---	67.34	67.34	---	28.69	28.69	---
Ark.....	63.78	50.64	13.14	56.72	71.15	60.19	10.97	61.21	38.62	22.59	16.55	15.06	1.48
Calif.....	109.01	96.97	12.04	296.66	133.35	118.31	15.04	114.03	98.11	15.92	43.95	41.08	2.86
Colo.....	95.16	79.94	15.21	192.30	88.75	70.25	18.50	77.79	62.69	15.11	38.60	35.36	3.23
Conn.....	68.49	62.98	5.52	201.34	96.70	69.28	27.42	68.44	43.86	24.58	43.78	39.15	4.63
Del.....	66.29	52.02	14.28	113.30	81.78	81.78	---	76.32	76.32	---	28.59	28.59	---
Dist. of Col.....	88.19	63.50	24.69	350.52	77.50	75.00	2.50	83.90	72.21	11.69	32.68	32.64	.05
Fla. 2/.....	62.70	49.38	13.32	337.94	65.84	60.15	5.69	65.71	56.30	9.41	15.67	15.16	.51
Ga.....	57.40	47.11	10.29	(3/)	59.45	56.00	3.45	60.88	54.52	6.37	22.17	22.17	(4/)
Guam 5/.....	74.78	74.78	---	212.24	(6/)	(6/)	---	(6/)	(6/)	--	15.23	15.13	.10
Hawaii 2/.....	78.34	72.57	5.77	285.55	112.88	81.29	31.58	111.60	71.79	39.80	41.26	39.68	1.57
Idaho.....	73.77	62.98	10.79	140.25	73.54	72.89	.64	58.19	50.25	7.93	39.27	39.27	---
Ill. 2/.....	96.02	46.18	49.83	423.10	96.54	62.84	33.70	101.53	67.22	34.31	44.71	37.93	6.77
Ind.....	88.29	44.39	43.89	176.38	98.61	61.66	36.95	119.07	49.17	69.90	29.39	23.70	5.69
Iowa.....	96.29	57.32	38.97	131.93	101.71	91.99	9.72	86.02	86.02	---	38.42	34.58	3.84
Kans. 2/.....	92.34	70.61	21.73	149.46	96.99	79.55	17.44	109.91	90.13	19.78	37.72	32.53	5.19
Ky. 2/.....	63.73	49.21	14.53	39.19	73.09	62.95	10.14	77.89	61.86	16.03	25.10	21.74	3.36
La.....	84.96	66.87	18.09	161.71	81.62	78.81	2.80	58.85	52.96	5.89	23.29	22.84	.46
Maine 2/.....	83.53	52.54	31.00	257.06	85.62	73.12	12.50	90.42	69.92	20.50	28.83	27.47	1.37
Md. 2/.....	89.38	44.63	44.76	45.71	85.12	64.11	21.01	91.21	64.78	26.43	35.56	35.56	---
Mass.....	92.52	69.94	22.58	174.76	143.60	130.45	13.14	144.91	67.26	77.64	47.32	41.43	5.89
Mich.....	93.96	81.74	12.22	368.67	86.51	80.59	5.92	99.14	85.68	13.46	35.51	34.64	.87
Minn.....	90.49	55.38	35.11	187.24	112.38	75.45	36.93	74.20	58.29	15.92	50.26	42.34	7.92
Miss.....	38.74	37.58	1.16	(3/)	45.20	44.85	.35	43.86	43.86	---	9.16	9.16	---
Mo.....	69.69	58.07	11.62	(3/)	75.00	75.00	---	73.52	67.80	5.71	24.31	23.67	.64
Mont.....	68.03	67.79	.23	(7/)	77.93	77.68	.26	69.64	69.64	---	36.30	36.30	---
Nebr.....	97.63	40.22	57.41	295.15	103.02	54.63	48.39	100.03	46.27	53.76	31.32	27.71	3.62
Nev.....	78.83	70.86	7.97	10.63	100.00	91.88	8.12	(3/)	(3/)	(3/)	31.66	29.70	1.96
N. H.....	104.00	80.50	23.50	25.23	109.03	89.60	19.43	116.10	79.65	36.44	44.31	36.13	8.19
N. J.....	89.25	64.97	24.28	227.75	88.68	76.49	12.19	100.93	71.25	29.68	50.35	47.30	3.04
N. Mex. 2/.....	80.58	58.24	22.33	(3/)	96.83	73.87	22.96	93.09	70.06	23.03	32.39	29.39	3.00
N. Y. 2/.....	97.65	73.58	24.07	336.36	125.78	84.79	40.99	135.85	73.09	62.75	47.54	41.64	5.90
N. C.....	63.11	53.61	9.50	23.03	71.21	66.08	5.14	68.65	59.83	8.82	24.61	23.08	1.54
N. Dak. 2/.....	120.33	65.83	54.50	322.91	93.95	68.82	25.12	164.42	63.89	100.54	49.05	37.05	12.00
Ohio.....	91.44	67.59	23.85	(3/)	85.81	69.74	16.06	81.58	64.66	16.92	32.46	28.66	3.81
Okla. 2/.....	97.23	76.40	20.83	165.49	123.35	102.62	20.74	113.12	92.37	20.75	34.86	32.35	2.51
Oreg.....	74.96	59.63	15.33	141.04	101.05	84.49	16.56	73.23	47.96	25.27	39.06	35.03	4.03
Pa.....	80.59	63.59	17.00	253.07	77.29	71.96	5.34	79.29	57.35	21.94	31.57	27.45	4.12
P. R. 2/.....	9.71	8.54	1.18	31.90	8.84	8.54	.29	8.78	8.61	.18	4.09	4.09	---
R. I. 2/.....	98.13	80.34	17.79	67.66	97.30	79.05	18.25	97.41	77.47	19.94	42.42	36.31	6.11
S. C.....	50.40	40.04	10.36	156.31	60.55	54.51	6.04	51.01	45.23	5.78	15.40	15.25	.15
S. Dak.....	69.54	52.54	17.00	47.03	70.69	70.69	---	58.26	58.26	---	32.48	32.48	---
Tenn.....	61.14	48.14	13.00	33.06	59.13	57.88	1.25	56.74	55.64	1.10	24.31	23.87	.44
Tex.....	71.17	57.56	13.61	(3/)	69.76	69.76	---	57.17	57.17	---	18.73	18.73	---
Utah.....	70.44	58.96	11.47	99.68	80.50	57.84	22.66	68.63	41.76	26.87	33.13	29.77	3.35
Vt. 2/.....	88.98	47.56	41.43	248.59	72.05	60.37	11.68	81.35	60.43	20.92	29.70	29.70	---
V. I. 5/.....	38.42	37.64	.78	48.51	(6/)	(6/)	(6/)	38.59	37.59	1.00	20.07	19.93	.14
Va.....	65.00	46.22	18.78	63.33	71.09	60.69	10.40	68.86	56.87	11.99	25.07	24.13	.94
Wash.....	91.58	60.72	30.86	148.89	99.65	66.94	32.72	68.71	29.56	39.15	36.28	29.31	6.96
W. Va.....	54.22	39.45	14.77	26.38	57.00	42.16	14.84	53.20	40.37	12.84	26.68	23.03	3.64
Wis.....	113.27	30.96	82.31	107.00	106.35	50.64	55.71	118.34	37.10	81.23	46.67	38.99	7.68
Wyo.....	83.80	68.89	14.91	(6/)	91.12	73.91	17.21	87.89	68.71	19.18	38.30	35.97	2.33

1/ Averages based on cases receiving money payments, vendor payments for medical care, or both. Money payments may also include small amounts for assistance in kind and vendor payments for other than medical care. Averages for general assistance not computed because of difference among States in policy or practice regarding use of general assistance funds to pay medical bills for recipients of the special types of public assistance. 2/ Except for aid to families with dependent children, data for each program represent average payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ No program in operation. 4/ Less than 1 cent. 5/ Data for June; July data not received. 6/ Average payment not computed on base of fewer than 50 recipients. 7/ Program in operation, but no payments made in July.

Table 14. Proportion of population receiving public assistance (recipient rates), by State, June 1965

/All programs except general assistance include recipients receiving only vendor payments for medical care. All data subject to revision/

State	Recipients of old-age assistance per 1,000 population aged 65 and over	Recipients of medical assistance for the aged per 1,000 population aged 65 and over	Recipients of aid to the blind per 100,000 population aged 18 and over	Recipients of aid to the permanently and totally disabled per 1,000 population aged 18-64	Children receiving aid to families with dependent children per 1,000 population under age 18	Recipients of general assistance per 1,000 population under age 65
United States average 1/...	117	2/ 17.4	78	5.3	46	3/ 4.0
Alabama	394	.9	88	8.2	44	(4/)
Alaska	196	---	99	2.1	34	3.1
Arizona	115	---	87	4.5	48	3.4
Arkansas	287	14.9	158	9.4	33	.6
California	175	20.2	5/ 106	7.2	63	1.9
Colorado	235	33.2	21	6.0	46	2.9
Connecticut	25	28.0	17	5.4	44	4.9
Delaware	36	3.3	103	1.7	46	5.8
Dist. of Col	31	10.8	39	7.5	64	1.2
Florida	105	1.2	70	5.9	42	(6/)
Georgia	288	---	12[illegible]	12.0	34	1.2
Guam	104	---	27	1.8	15	.3
Hawaii	33	15.0	20	3.6	36	2.0
Idaho	65	38.6	32	8.8	27	(6/)
Illinois	52	1.4	35	5.2	53	5.4
Indiana	48	.9	58	.6	20	(6/)
Iowa	78	15.0	64	.9	33	3.3
Kansas	84	11.5	36	4.5	37	3.3
Kentucky	192	40.5	128	6.9	51	1.0
Louisiana	497	2.3	133	10.9	56	2.8
Maine	98	5.4	49	4.5	38	9.3
Maryland	40	46.1	18	4.2	50	2.9
Massachusetts	86	50.4	64	4.6	40	3.2
Michigan	69	9.2	33	2.8	38	7.4
Minnesota	81	37.0	48	2.2	30	7.9
Mississippi	363	---	191	16.6	71	.7
Missouri	193	---	5/ 150	6.4	53	3.2
Montana	77	---	57	3.9	21	4.9
Nebraska	72	1.9	68	3.6	24	(6/)
Nevada	127	---	59	---	26	1.4
New Hampshire	60	31.0	61	1.8	15	4.6
New Jersey	22	8.6	21	2.3	36	7/ 4.9
New Mexico 8/	167	---	62	7.8	50	.6
New York	31	19.8	26	3.6	66	6.8
North Carolina	121	6.0	166	8.8	46	.9
North Dakota	83	23.4	21	5.4	25	2.1
Ohio	86	---	51	3.6	38	8.0
Oklahoma	307	4.2	102	11.1	64	(6/)
Oregon	50	20.3	38	8.0	36	(6/)
Pennsylvania	38	9.6	5/ 231	3.3	53	4.1
Puerto Rico	202	24.9	96	16.1	131	1.0
Rhode Island	60	90.9	18	5.9	57	8.2
South Carolina 8/	150	7.4	127	6.9	23	.6
South Dakota	89	8.0	26	3.2	32	2.1
Tennessee	134	31.7	85	6.5	43	.9
Texas	272	---	74	1.8	18	(6/)
Utah	70	36.6	30	10.1	39	5.2
Vermont	119	2.8	48	6.2	28	(6/)
Virgin Islands	167	52.6	44	2.8	45	5.4
Virginia	41	11.1	43	3.0	22	1.7
Washington	109	34.9	36	11.8	49	4.7
West Virginia	76	60.2	67	6.0	120	1.7
Wisconsin	64	15.9	31	3.0	22	5.0
Wyoming	83	1.6	27	4.0	23	3.8

1/ Based on civilian population as of July 1, 1965; estimated by the Bureau of the Census. 2/ Based on data for 44 States with programs in operations. Rate including population for States not making MAA payments is 14.4 per 1,000 aged persons. 3/ Based on data for 46 States. See footnote 6. 4/ Less than 0.05. 5/ Includes recipients of payments made without Federal participation. Recipient rates excluding these recipients are as follows: California 106; Missouri, 126; and Pennsylvania, 62. 6/ Number of persons aided not currently available. 7/ Includes an unknown number of persons receiving medical care, hospitalization, and burial only. 8/ May data; June data not received.

Old-age, survivors, and disability insurance benefits, summary data, July 1965

CURRENT MONTH DATA

Type of benefit	Benefits awarded in month		Benefits awarded in current-payment status, end of month			Amount of benefits paid 1/ in month (in thousands)
	Number	Average amount	Number	Monthly rate (in thousands)	Average amount	
Total, OASI and DI	318,516	---	---	---	---	$1,416,708
Total, OASI	276,138	---	---	---	---	1,295,203
Monthly benefits, OASI and DI	228,647	---	20,243,272	$1,364,720	---	1,398,331
Monthly benefits, OASI	186,269	---	18,580,905	1,257,182	---	1,276,826
Monthly benefits, DI	42,378	---	1,662,367	107,539	---	121,506
Old-age (retired-worker)	95,035	$84.80	10,891,811	850,167	$78.06	856,011
Disability (disabled-worker)	20,579	94.01	950,339	86,637	91.16	96,991
Wife's or husband's (OASI and DI)	33,282	39.57	2,793,746	111,365	39.86	114,477
Wife's or husband's (OASI)	26,940	40.91	2,604,916	105,297	40.42	107,171
Wife's or husband's (DI)	6,342	33.85	188,830	6,068	32.13	7,306
Widow's or widower's	24,022	74.16	2,242,039	153,461	68.45	158,626
Parent's	283	81.51	35,736	2,521	70.55	2,741
Child's (OASI and DI)	46,904	---	2,854,470	132,304	---	139,657
Child's (OASI--total)	31,447	---	2,331,272	117,470	---	122,448
Child's (OASI--life) 2/	8,196	29.94	429,845	12,155	28.28	12,661
Child's (OASI-survivor) 2/	23,251	52.75	1,901,427	105,315	55.39	109,787
Child's (DI)	15,457	27.92	523,198	14,833	28.35	17,209
Mother's	8,542	61.39	475,131	28,265	59.49	29,829
Lump sum death payments	89,869	3/217.99	---	---	---	18,377

COMPARATIVE DATA

Item	July 1965	June 1965	July 1964
Number of benefits in current-payment status, end of month:			
Total, OASI and DI	20,243,272	20,156,883	19,563,658
Total, OASI	18,580,905	18,508,707	18,039,068
Total, DI	1,662,367	1,648,176	1,524,590
Amount of benefits paid (in thousands):			
Total, OASI and DI	$1,416,708	$1,429,273	$1,353,096
Total, OASI	1,295,203	1,302,972	1,243,431
Total, DI	121,506	126,301	109,665
Number of old-age (retired-worker) benefits:			
Awarded	95,035	99,667	89,242
In current-payment status, end of month	10,891,811	10,842,620	10,539,162
Average old-age (retired-worker) benefit:			
Awarded	$84.80	$82.50	$81.34
In current-payment status, end of month	78.06	77.98	77.37
Number of disability insurance (disabled-worker) benefits:			
Awarded	20,579	23,947	18,009
In current-payment status, end of month	950,339	943,672	868,042
Average disability insurance (disabled worker) benefit:			
Awarded	$94.01	$93.75	$95.41
In current-payment status, end of month	91.16	91.14	90.90
Number of persons aged 62 and over receiving monthly benefits, end of month (OASI and DI) 4/	15,836,000	15,766,000	15,304,000
Number of persons aged 65 and over receiving monthly benefits, end of month (OASI and DI) 4/	13,934,000	13,869,000	13,441,000
Assets of trust funds, end of month (in millions):			
OASI	$19,437	$20,180	$18,973
DI	1,928	2,007	2,192

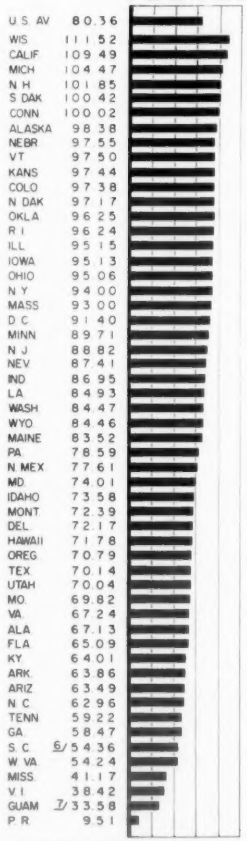
1/ Exceeds monthly amount of benefits in current-payment status because initial payments include amounts payable for prior months. Distribution by type of monthly benefit estimated.
2/ Distribution by type of claim for OASI child's benefits estimated.
3/ Average lump-sum per worker; 84,300 deceased workers represented in the current month's lump-sum awards.
4/ Numbers estimated to the nearest thousand.

Source: Division of the Actuary, Social Security Administration.

AVERAGE MONTHLY PUBLIC ASSISTANCE PAYMENT PER RECIPIENT, JUNE 1965

(EXCEPT FOR GENERAL ASSISTANCE, INCLUDES VENDOR PAYMENTS FOR MEDICAL CARE)

OLD-AGE ASSISTANCE

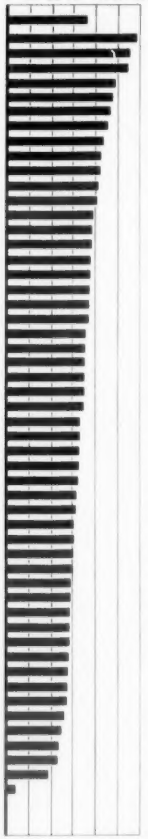


U.S. AV	80.36
WIS	111.52
CALIF	109.49
MICH	104.47
N.H	101.85
S.DAK	100.42
CONN	100.02
ALASKA	98.38
NEBR	97.55
VT	97.50
KANS	97.44
COLO	97.38
N.DAK	97.17
OKLA	96.25
R.I	96.24
ILL	95.15
IOWA	95.13
OHIO	95.06
N.Y	94.00
MASS	93.00
D.C	91.40
MINN	89.71
N.J	88.82
NEV	87.41
IND	86.95
LA	84.93
WASH	84.47
WYO	84.46
MAINE	83.52
PA	78.59
N.MEX	77.61
MD	74.01
IDAHO	73.58
MONT	72.39
DEL	72.17
HAWAII	71.78
OREG	70.79
TEX	70.14
UTAH	70.04
MO	69.82
VA	67.24
ALA	67.13
FLA	65.09
KY	64.01
ARK	63.86
ARIZ	63.49
N.C	62.96
TENN	59.22
GA	58.47
S.C	6/54.36
W.VA	54.24
MISS	41.17
V.I	38.42
GUAM	7/33.58
P.R	9.51

MEDICAL ASSISTANCE FOR THE AGED 1/

U.S. AV	190.48
D.C	472.38
MICH	428.25
ILL	362.93
NEBR	344.95
N.Y	339.02
FLA	335.95
ALA	316.35
CALIF	310.13
MAINE	261.58
HAWAII	259.58
PA	244.74
N.DAK	232.71
N.J	227.46
VT	219.52
MINN	194.83
CONN	194.75
DEL	191.65
N.C	186.86
IND	182.24
MASS	180.91
COLO	171.44
S.C	6/170.43
LA	159.13
KANS	158.54
OREG	147.99
WASH	146.38
OKLA	141.58
IDAHO	138.75
WIS	132.86
IOWA	110.08
UTAH	98.00
VA	70.76
ARK	61.32
R.I	56.84
N.H	51.95
V.I	48.51
S.DAK	47.03
TENN	32.55
KY	28.17
W.VA	26.30

AID TO THE BLIND 2/

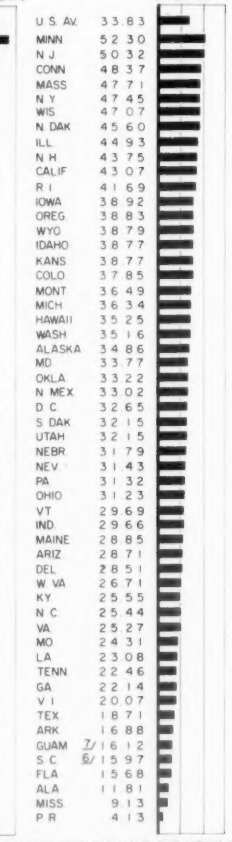


U.S. AV	87.88
CALIF	145.15
MASS	137.18
CONN	135.01
OKLA	122.26
NEV	118.92
N.Y	116.67
MINN	112.22
N.H	108.21
WIS	107.48
NEBR	105.82
IOWA	102.66
KANS	101.06
ILL	96.62
HAWAII	95.62
WYO	95.04
MICH	94.27
R.I	94.13
N.MEX	94.00
WASH	93.01
N.DAK	92.80
OREG	89.57
IND	88.69
N.J	88.67
MONT	88.02
COLO	87.41
MAINE	86.46
ALASKA	83.89
OHIO	83.02
DEL	82.60
LA	81.34
MD	80.99
VT	78.78
D.C	78.42
PA	75.84
UTAH	75.42
MO	75.00
KY	74.59
VA	72.51
IDAHO	71.93
ARIZ	71.67
ARK	70.62
N.C	70.19
TEX	69.66
ALA	68.78
S.DAK	68.46
FLA	68.01
S.C	6/64.18
GA	60.69
W.VA	57.63
TENN	55.84
MISS	45.89
P.R	8.80

AID TO THE PERMANENTLY AND TOTALLY DISABLED 3/

U.S. AV	84.65
ALASKA	167.04
MASS	151.59
IND	135.66
N.Y	134.72
N.DAK	133.34
WIS	122.99
N.H	118.50
CALIF	117.68
HAWAII	117.39
MICH	115.02
KANS	114.65
OKLA	112.23
ILL	101.43
N.J	101.43
NEBR	97.95
R.I	96.14
CONN	90.59
MAINE	90.37
N.MEX	90.24
VT	86.86
MD	86.55
IOWA	83.36
WYO	83.34
D.C	83.12
COLO	79.57
MONT	79.13
OHIO	78.61
KY	78.14
PA	77.54
N.C	77.19
DEL	76.55
MO	72.75
VA	71.01
S.DAK	70.18
FLA	68.52
OREG	68.27
ARIZ	67.30
UTAH	67.10
WASH	65.84
ARK	61.87
GA	61.49
MINN	61.34
LA	58.75
IDAHO	57.38
TEX	57.13
TENN	55.11
S.C	6/54.53
W.VA	53.27
ALA	46.34
MISS	43.90
V.I	38.59
P.R	9.16

AID TO FAMILIES WITH DEPENDENT CHILDREN



U.S. Av.	33.83
MINN	52.30
N.J	50.32
CONN	48.37
MASS	47.71
N.Y	47.45
WIS	47.07
N.DAK	45.60
ILL	44.93
N.H	43.75
CALIF	43.07
R.I	41.69
IOWA	38.92
OREG	38.83
WYO	38.79
IDAHO	38.77
KANS	38.77
COLO	37.85
MONT	36.49
MICH	36.34
HAWAII	35.25
WASH	35.16
ALASKA	34.86
MD	33.77
OKLA	33.22
N.MEX	33.02
D.C	32.65
S.DAK	32.15
UTAH	32.15
NEBR	31.79
NEV	31.43
PA	31.32
OHIO	31.23
VT	29.69
IND	29.66
MAINE	28.85
ARIZ	28.71
DEL	28.51
W.VA	26.71
KY	25.55
N.C	25.44
VA	25.27
MO	24.31
LA	23.08
TENN	22.46
GA	22.14
V.I	20.07
TEX	18.71
ARK	16.88
GUAM	7/16.12
S.C	6/15.97
FLA	15.68
ALA	11.81
MISS	9.13
P.R	4.13

GENERAL ASSISTANCE 4/

U.S. Av.	31.33
D.C	70.62
MD	61.83
HAWAII	56.69
PA	52.95
MO	51.54
LA	47.25
WASH	45.91
N.Y	40.05
N.J	5/39.26
NEV	38.94
CALIF	38.79
ILL	37.77
MASS	37.03
V.I	35.19
DEL	30.78
KANS	29.89
WIS	29.29
MINN	27.72
S.C	6/27.37
CONN	26.47
MICH	26.26
R.I	25.96
UTAH	25.65
W.VA	23.56
N.MEX	23.19
ARIZ	23.17
OHIO	22.07
WYO	21.23
VA	20.10
N.H	18.99
MONT	17.64
ALASKA	16.39
TENN	16.22
N.DAK	14.99
GA	14.82
MAINE	13.50
ALA	13.28
KY	12.97
COLO	12.56
MISS	12.00
N.C	9.82
P.R	9.53
S.DAK	9.51
ARK	4.32

1/ NOT COMPUTED FOR GUAM AND WYOMING, FEWER THAN 50 RECIPIENTS, AND MARYLAND AND PUERTO RICO, DATA ESTIMATED. NO PROGRAM IN REMAINING STATES. 2/ NOT COMPUTED FOR GUAM AND THE VIRGIN ISLANDS, FEWER THAN 50 RECIPIENTS. 3/ NO PROGRAM FOR NEVADA. NOT COMPUTED FOR GUAM, FEWER THAN 50 RECIPIENTS. 4/ NOT COMPUTED FOR GUAM, FEWER THAN 50 RECIPIENTS, AND FLORIDA, IDAHO, INDIANA, IOWA, NEBRASKA, OKLAHOMA, OREGON, TEXAS, AND VERMONT, DATA NOT AVAILABLE. 5/ BASED ON DATA INCLUDING AN UNKNOWN NUMBER OF CASES RECEIVING MEDICAL CARE, HOSPITALIZATION, AND BURIAL ONLY, AND TOTAL PAYMENTS FOR THESE SERVICES. 6/ MAY DATA, JUNE DATA NOT RECEIVED. 7/ MARCH DATA, LATER DATA NOT AVAILABLE.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Welfare Administration
WASHINGTON, D. C. 20201

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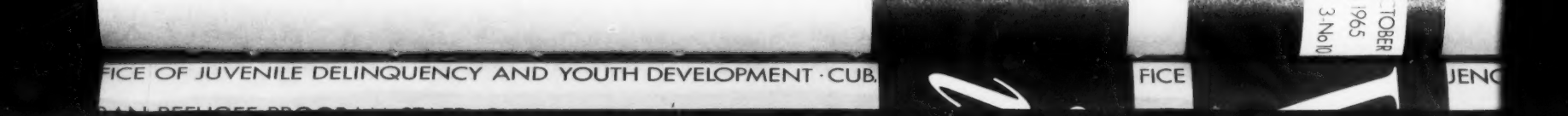
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